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Ideals for Service and Education[1]

ELNORA E. THOMSON, R.N.

NURSING came into existence because of human need for such service, and as we look back through history we find many interesting figures who stand out with striking distinctiveness because of the service they rendered humanity.

We find Phoebe, the early Christian, concerning whom St. Paul said, "She was the succorer of many and of myself also." And we know that St. Paul did not always speak so favorably in regard to women.

After Phoebe there were many who devoted themselves to the care of the sick and the poor. In these early days the only requisite for those wishing to enter upon careers as nurses was that they have a service ideal—an ideal, however, strong enough to lead them to devote their lives to helping those who could not help themselves. There were among this group many eminent and learned women such as the Abbess Hildegarde who ruled over a large establishment and was skilled in the art of medicine, as well as in that of nursing, but not until the time of St. Vincent de Paul did anyone clearly help others to see that the service ideal was not sufficient, that there must be education as well if this ideal were to be made effective, and when, with the help of Mlle. Le Gras, he organised the Sisters of Charity, there was a definite plan for nursing education. A similar plan was later followed by Pastor Fliedner who, with his wife, Frederike, organised the Deaconesses of Kaiserswerth.

These two organisations, based as they were upon the service ideal and the need for education in nursing, and working in both hospitals and homes, gave Florence Nightingale her opportunity for observing methods in caring for the sick, for while traveling on the Continent she spent some time with each of these groups and she put her observations into effect when she utilised these methods in developing the military hospitals in Crimea, when she was asked to help her country. Many people think of Florence Nightingale rather vaguely as someone who intuitively knew nursing and organisation, and not at all as she was in her younger years when she not only had an overwhelming desire to serve the sick, but was also an indefatigable seeker after knowledge as to how this might be done in the best way possible, and do not realise that it is because of this intelligent preparation that she was able to give the service for which she stands today, as she has stood through all of these years, as a symbol of all that which the nursing profession is still striving to attain. For nursing today is attempting, as did St. Vincent de Paul, Pastor Fliedner and Florence Nightingale, to meet human needs effectively by acquainting itself with all available pertinent knowledge so that its service may be effectively rendered. There were others of her time besides Miss Nightingale who were interested in the education of lay women as nurses. Two other schools were established before the Nightingale School of Nursing came into existence, but Miss Nightingale, with her personality, experience, and spectacular service in military hospitals, stands out because, according to her biographer, Sir Edward Cook, she was prepared to "make public opinion perceive and act upon the perception that nursing was an art and must be raised to the status of a trained profession, and that the means by which she achieved this great work were three—by her example, her precept, and her practice."

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[1] Address of the Acting President of the American Nurses' Association, read at the opening session of the biennial convention of the three national nursing organizations, Milwaukee, June [illegible], 1930.

It was not long after the development of the Nightingale School of Nursing before such schools were formed in the United States, and with a look into the future the women who had put forward this movement here soon began to appreciate the need for some form of organisation for nurses, so the Superintendents' Society was organised, now the National League of Nursing Education, and this was followed very shortly afterward by the Associated Alumnae, which is now our American Nurses' Association. This year this Association celebrates its thirty-fourth birthday.

When the history of our Association is reviewed, it is appreciated that many things have happened during these years, and it seems appropriate at this time to note a few of them.

First of all, we take pride in our form of organisation, which has come to us through the forward thinking of those nurses who in former years have led the nurses of this country to act soundly in developing this Association, which now counts in its membership more than 84,000 individual nurses. These, however, come to the American Nurses' Association not as individual members in the national association, but as individual members in their state association.

The state association is divided into district associations and these are made up of alumnae associations and of individuals whose alumnae associations happen to be in other states.

We are frequently asked how can an organisation with so large a membership as ours and scattered over so large a territory serve the individual patient? Our answer is through our democratic form of membership, from the individual nurse to the district, to the state, to the national, and even to the International Council of Nurses, and vice versa from the national association, with its House of Delegates and its Advisory Council, made up of state presidents to the states, to the districts, to the individual nurse and through her to the individual patient.

The effectiveness of our organisation has been demonstrated. In an effort to protect the patient who needs skilled service and to give nursing a professional status, as well as to protect the well prepared nurse, the American Nurses' Association has, through its state associations, secured in every state and in Porto Rico and Hawaii, a nurse practice act. Some of these acts carry only minimum standards, but some of them are quite advanced.

Another impressive thing is the multiplication of schools of nursing in the United States. In the lifetime of the first graduate nurse, Linda Richards, schools for nursing have been started in all but one state of the United States, so that now there are some 2,000 or more. This all indicates that there is a need for the service which the nurse, when educated, is prepared to give. However, this rapid growth has not always been sound growth, and now an attempt is being made to find out about the quality of the product of these schools, with the idea that quality is more important than quantity. To do this nursing has undertaken to examine itself through the Committee on Grading Schools of Nursing, which is now in the fourth year of its five-year study. This study has brought to light information about the lack of employment experienced by many graduate nurses, and this has led this Association to consider its responsibility for the graduates of schools of nursing in the matter of economic security. It would seem that in the past, to some extent, the distribution of the services of nurses has followed the needs for nursing; for instance, district nursing developed to serve the economically dependent group, and this service has expanded and changed so that it now enters the field of the prevention of disease and the building of health. In some instances it has even met the needs of the economically independent in the smaller-incomed group, through a cost charge for bedside service. This latter group, however, is still largely without skilled nursing service, and therefore, the American Nurses' Association is somewhat concentrating its resources in the study of the nursing needs of this moderate-salaried individual and family in an effort to find out the part which the nurses' official registry, now pretty firmly established, may have in giving this needed nursing service.

Too long, in many instances, the registry has been regarded as merely an employment bureau for nurses rather than as, in addition, a distributing center for nursing service in the community. It has been found through trial in several places, that it can be such a distributing center, so that this larger view of the registry is not only sound from the standpoint of service to the patient in extending nursing service to all those who need her care, but also from the standpoint of the nurse, for in the light of our knowledge of economic conditions in the United States, it is obvious that the time has come when it is essential that the distribution of the services of nurses must be done more in line with modern practices.

In this biennial meeting, therefore, interest on this subject will be focused in the registry round tables, the joint meeting, Tuesday morning, with its program on "Nursing the Community," and in the meeting of the Private Duty Section, in all of which questions pertaining to this subject will be discussed.

Much more information has come from the studies of this Committee on Grading Schools of Nursing which is, in reality, because of the methods employed, a self-analysis of our profession by ourselves and as a result we believe will come knowledge of the needs of the present-day patient, whom we serve in coöperation with the present-day practitioner of both curative and preventive medicine.

Judging the present in nursing by the past, we believe there will be worked out by our nurse educators and leaders new programs not only for the education of nurses, but also for the practice of nursing as a profession. These plans will then be discussed in our state groups, modified by suggestions from the clear thinking individual nurses—and then in their modified form they will be accepted by our Association as a whole and put into practice by each of us as an individual for our service to our individual patients.

With our form of organization, nothing can be imposed from the national association to the state, but rather must decisions be made by our groups of states in our House of Delegates.

So, granted that the nurse is still actuated by the service ideal and seeks knowledge as did Florence Nightingale as preparation for service, then when we are in majority agreed upon our newer plans of procedure in nursing education and practice, we shall by "our example, our precept and our practice" create a public opinion which shall make effective through our 84,000 members our service to our individual patients and also make our contribution a part of the larger contribution for service which is being rendered by organizations similar to our own, but working in other fields of endeavor, actuated, however, by the same ideal for service.

In preparing this message I have made every effort to follow the lines of thought which were Miss Clayton's for her message to you, so I ask that you will feel, as I do, that this is not my message, but that it comes from her and that she asks us to carry forward her ideals for service and education, as well as our own, in the democratic spirit in which she believed and which she did all in her power to foster.

Voluntary Organizations Are Trustworthy

THERE has grown up a large class of organizations known as voluntary health associations. These owe their being to the fact that the wheels of government are slow to be set in motion. Science has far outstripped, with its discoveries, the application of the facts that it has made available. Government is conservative, and probably fortunately so, else the number of crack-brained reform schemes that have been enacted into laws of the land would be greater than it is. On the other hand, the conservatism of officialdom leaves vast needs uncared for, and into this breach the voluntary organizations have stepped. These draw their maintenance, not from taxes, but from public contributions or philanthropic individuals or both. There are many of them; some think too many, yet they are organized for worthy purposes; no one can gainsay that. In general, these voluntary organizations are reliable sources of health information. Among them two types may be distinguished: the associations of professional people, organized for the advancement of their profession through better service for the public health, and those with a distinct and often circumscribed objective in the health field. The latter are frequently lay organizations, though supplied with professional service and advice.

In the first group fall such organizations as the American Medical Association with its component state and county societies, the American Public Health Association, the American Nurses' Association, the National Organization for Public Health Nursing and the State and Provincial Health Officers' Association of North America.

In the second group are the American Child Health Association, the American Social Hygiene Association, the National Tuberculosis Association, the National Committee for the Prevention of Blindness, the American Heart Association and others too numerous to mention. Their names state their purpose, and each purpose is one that we may [illegible] and support, while at the same time we wonder whether it would not be possible to save effort, money and overlapping by consolidation. In the meantime, we may look to each of these groups as sources of authentic information in their respective fields. We may depend upon them. They answer authoritatively the question, Who says so?—From "Who Says So?" by W. W. Bauer, in *Hygeia*, December, 1929.

How Trained Nurses Can Help with the Cancer Problem

GEORGE GRAY WARD, M.D.

ONE of the important functions of the trained nurse is to impart authentic facts regarding our knowledge of diseases and their treatment to those with whom she comes in contact. This applies not only to her individual patients, but to all in the immediate family and to friends, whenever such information is pertinent and requested. In this way valuable aid may be given toward educating the lay public to an understanding of rational medical facts, and the trained nurse may thus help to combat the baneful influence and serious harm to the public welfare done by the various medical cults and fads which are everywhere continually trying to exploit the gullible for purely financial ends. Especially is this so of cancer; and as cancer of the uterus is so common, it is peculiarly the province of the trained nurse to advise women on this delicate subject.

The fact that most women associate pain with cancer accounts for their ignoring the earliest symptoms of this treacherous disease. Would that pain were the earliest symptom, for then we would have many more women seeking relief in time to enable a cure to be effected. Unfortunately pain is only a terminal symptom which comes when the disease has progressed into the deeper structures beyond the uterus and when little can be done beyond temporary palliation. The same is true of odor. The foul odor associated with cancer is due to putrefaction of tissue, and is likewise a terminal symptom.

The earliest symptom is a blood-tinged leucorrhoea, often only a pinkish discharge, and not necessarily profuse. Irregular bleeding, at first, scanty and not usually excessive, comes next. Severe hemorrhages occur in the advanced stages of the disease. Now as women are accustomed from adolescence to the monthly bloody discharge of menstruation, which is often preceded and followed by a slight leucorrhoea or hypersecretion, it is manifestly unreasonable to expect them to become alarmed at the appearance of a little bloody leucorrhoea, and so they neglect it, failing to appreciate the importance of the dictum that *"any irregular bleeding however slight and at any age must be regarded with suspicion until proved to be without significance."* The writer has seen a case of cancer in a girl of 19 years, and many in young women in the twenties and thirties. It is true that the majority of cases occur in women in the forties and fifties, that is, at the time of the menopause, and due to the common belief that irregularity in appearance and quantity of the menstrual flow is to be expected during this period, this irregularity is disregarded as unimportant or natural when it frequently is the first manifestation of cancer.

Unfortunately, it is not only the laity who make this false assumption. Physicians and nurses also have been responsible for fatal delay in either making a proper examination or in advising competent consultation.

Our statistical studies at the Woman's Hospital have shown that in a series of 177 patients, the average duration of symptoms was seven months. There were only ten cases in which advice was sought within the first month of the onset of symptoms. When we realize that in the early cases we have a chance of saving 50 per cent by prompt treatment, and that if the disease has progressed beyond the initial stage, the percentage is less than 25, the importance of educating women to seek proper consultation for any irregular bleeding or discharge is apparent.

The trained nurse has by the nature of her duties an exceptional opportunity to impart these facts to those with whom she comes in contact, and to carry the message that with our present knowledge all cases of cancer of the uterus are by no means doomed; that if relief is sought in the early stages 50 per cent at least can be salvaged, and nearly one in four of all cases without the use of the knife in most instances.[1]

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[1] The New York Cancer Committee, of which Dr. Ward is a member, will be glad to furnish, without charge, further information on cancer control, if the request is made to the office, 34 East 75th Street, New York.

The Nursing Care of Cancer Patients

Some Recent Developments

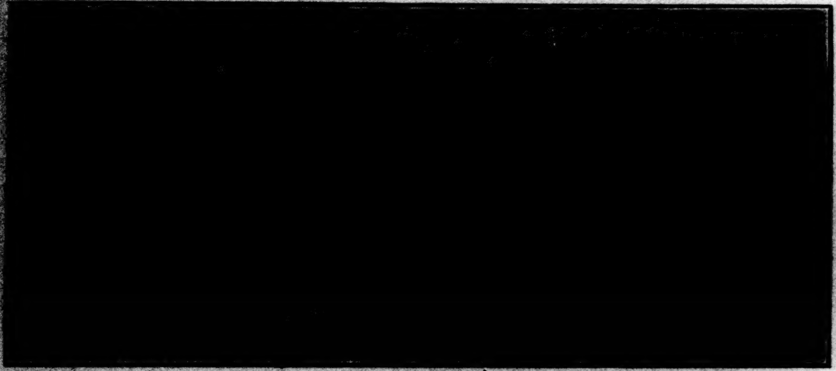
ANNE A. FERRIS, R.N.

CANCER has been known for centuries, and scientists have spent their entire lives in efforts to discover its cause. Many theories have been advanced, but the cause or causes remain undetermined; many measures are known to alleviate the suffering to a great extent, but no specific cure has been found. Radium and x-ray have been used extensively during recent years. Their advent has changed somewhat the type of nursing care given to patients suffering from cancer.

New problems have arisen incident to treatment by irradiation; a new type of inflammation is created and cared for. This means that cancer patients must have exquisite nursing care if they are to be kept comfortable without drugs. The nurse is ever alert for symptoms arising and is ready with combative treatments. The radiation of growths involving the outer surfaces of the body is at times followed by breaking down of tissue. Much of the pain and discomfort from which these patients suffer is due, not so much to the growth itself, as to the accumulation of sloughing tissue and to secondary infections which result when this necrotic tissue is not removed. Prevention of secondary infections is, then, a large factor in keeping the cancer patient comfortable and must be carefully and constantly combated. It is possible to do this only by frequent irrigation of the sloughing areas.

The attitude toward cancer nursing is changing. Optimism is a most essential factor at all times. Encouragement given and frequently stimulated—must never be allowed to waver in any way. The nurse must never accept the case as "hopeless," but one in which intense interest must always be shown.

When the growth involves an antrum or an eye, continuous wet dressings of boric acid or saline, with hourly irrigations of the same solutions, are given during the first twenty-four hours following operation. When the throat, tonsils, floor of the mouth, or hard palate are affected, irrigations



TRACHEOTOMY SET

are given hourly as well as before and after each feeding. If the patient is unable to swallow, a nasal tube is passed and the patient fed in this manner until he can swallow without difficulty. It is particularly important to keep clean the areas on which plastic work has been done, since the accumulation of even a very little pus may ruin an entire skin graft.

The sloughing or secondary necrosis incident to radiation is usually severe and a very important nursing problem met with constantly. Here again the nurse exercises great nursing care in keeping these patients comfortable without narcotics. It is to the nurse the duty falls in checking this necrosis. The part which has been irradiated is watched carefully—vaseline gauze applied (irradiated areas are kept moist)—slough removed and frequent irrigations given.

Unless the parts are kept clean the condition known as leukoplakia may result. Leukoplakia is the development on the mucous membrane of white thickened patches which are removed with great difficulty. The possibility of their developing is great, their prevention is almost entirely the responsibility of the nurse.

A quart-size enamelware irrigating can with rubber tubing and glass tip are used for irrigations. The towel protecting the patient is held in place by a napkin holder consisting of two metal clips held together by a metal chain. A short piece of soft collapsible rubber tubing is slipped over the end of the irrigating tip, making it possible to reach into all parts of the mouth or throat without discomfort to the patient. After the first twenty-four hours, in addition to the hourly irrigations, these areas are cleansed by means of a pressure apparatus which forces the solution in a fine spray into every part of the mouth and throat. The treatment is not at all painful to the patient; on the contrary the thorough cleansing which follows is a great relief to him.

Patients who come to the hospital for gastrostomy operation require different care from those with lesions of the face, neck or mouth. There are no sloughing places to care for even after operation. The problem is instead one of building up the patient's physical condition to the point where he can be operated upon and, after operation, of feeding him and teaching him, if possible, to feed and care for himself. In these cases the feeding problem is paramount.

Frequently these unfortunates put off coming into the hospital until they are *forced* to by the fact that the growth has reached the point where the esophagus is entirely blocked and the swallowing even of water is no longer possible. As a result they are very much dehydrated and undernourished, and it is necessary to give them fluids by rectum and hypodermoclysis before they can be operated upon with safety.

After the gastrostomy operation, feedings of peptonized milk are started as soon as possible, usually about four hours after operation. Beginning with two ounces of milk every two hours, the feedings are increased one ounce each day until from twelve to sixteen ounces are being given at each feeding. In addition to this, for the first week, six ounces of 10 per cent glucose solution in 2 per cent sodium bicarbonate solution are given every *four* hours by rectum. On the third day a cathartic, such as one ounce of castor oil, is given through the feeding tube in order to establish peristalsis. As in the case of all patients who are receiving fluids by rectum, it is important that the lower bowel be emptied regularly in order that the fluid be absorbed. A cleansing enema is, therefore, given daily.

During the first week the feeding tube is left in the gastrostomy opening into the stomach and is shortened an inch each day until about the seventh day, when it is removed entirely. At that time the sutures are removed and the feeding tube can then be inserted at each time of feeding. A number 12 or 14 rubber catheter and glass funnel are used in giving the feedings. On the *fourth* day the milk is no longer peptonized—plain milk is substituted with the addition of one ounce of lactose with each feeding. Granulated sugar is never used. On the sixth day one egg, one ounce of lactose and nine ounces of milk are used for each feeding. After the eighth or ninth day pureed soups are allowed, and butter once a day. The patient is also allowed to hold cracked ice in his mouth, although he may not swallow it. In these cases the mouth, teeth, and tongue are cleansed every hour with paste and a brush, followed by a mouth wash of saline solution.

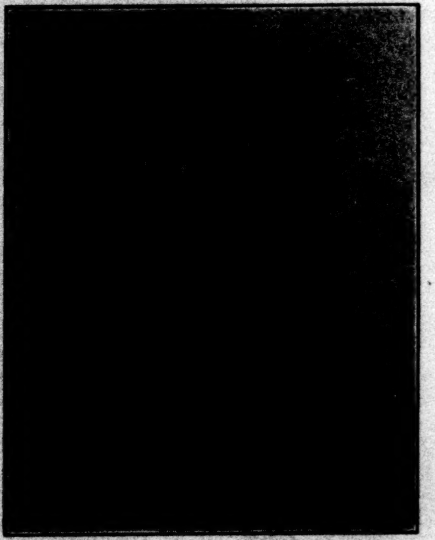
Patients who have had a tracheotomy are much distressed by the accumulation of mucus which clogs the tracheotomy tube and interferes with breathing. It has been found in these cases that frequent use of the suction apparatus by means of a small catheter inserted into the tracheotomy tube is an effective way of removing the mucus and of reducing the possibility of pneumonia. The inner tracheotomy tube is also removed and cleansed frequently, and, while the patient is in the hospital, at least once a day the outer tracheotomy tube is also removed and cleansed. This last is done only during the time that the patient is in the hospital, where surgical aid is at hand, since any difficulty in replacing the tube might result in suffocation and death.

It is important that these patients be gotten out of bed as soon as possible after operation, since their vitality becomes lowered very quickly if they remain in bed very long. Most throat cases are allowed, or rather urged, to get up in from twenty-four to forty-eight hours. Gynecological cases are kept in bed—for insertion of radium three days—for abdominal surgery, fourteen days. Patients who have had radical breast amputations are allowed out of bed on the third day; those who have had only local insertion of radium are up in twenty-four hours.

In colostomy cases the bowel loop is opened on the third or fourth day, a cathartic (usually castor oil, one ounce) is given, then irrigation with potassium permanganate 1-10,000 is done. After two days this irrigation is done daily. Patients are allowed out of bed as their physical condition permits.

Surprising though it may be to nurses who have cared for cancer patients in general hospitals, and who have been accustomed to giving them large and frequent doses of narcotics to control their pain, in the hospitals which specialise in the treatment of cancer the average patient receives narcotics seldom or not at all except in cases of hemorrhage. Indeed the use of morphin for pain, except in extreme cases, is contra-indicated because the patient's tolerance for the drug increases rapidly and the gastric disturbance resulting from its constant use far outweighs its virtue in controlling pain. Instead, as has been said, emphasis is laid on nursing care and on the use of the measures described for keeping the wounds clean and free from secondary infection. Under these conditions the coal tar derivatives such as aspirin and other salicylates suffice to keep him comfortable. Codein is sometimes used, but sparingly, while allonal and luminal are given for inducing sleep.

There are certain emergencies always to be watched for among cancer patients, and so dire may be their consequences that no ward is ever left without a nurse, even for a few minutes. Perhaps the most common and most dreaded of these is hemorrhage. The danger is, of course, in proportion to the part of the body involved, and is due to the progress of the cancer or to the sloughing of tissue following radiation. A large proportion of these patients have lesions of the head and neck which may encroach on the jugular vein. Another common site for bleeding is the mouth. The onset of hemorrhage is usually sudden, although in some cases severe pain in the head and neck a day or two earlier may have warned the nurse of approaching disaster. The patient's life depends upon the speed with which treatment is given, and unless the bleeding is checked very quickly it may end fatally. The nurse must not only be able to recognise the emergency which is at hand, but must send for medical aid at once and have ready the materials which the doctor will need. She must also have a hypodermic of morphin ready to give.



TRACHEOTOMY—COMPLETE DRESSING

In stopping hemorrhage from the mouth, the simplest and often the most efficient means is a gauze tampon applied to the bleeding surface and held by digital pressure. Pressure must be maintained until clotting has taken place. An ice collar may also be placed about the throat. Clamping a spurting artery at the base of a sloughing area is difficult, and the doctor may apply a ligature. Ligation of the neck vessels is frequently done by the doctor if the bleeding is arterial. In the tonsillar region the bleeding may be from erosion of the jugular vein, in which case ligation is not possible and other means such as pressure, ice, and morphin are used. If the bleeding can be controlled there is always a fair chance that the area will heal. Blood transfusion is always arranged for tentatively.

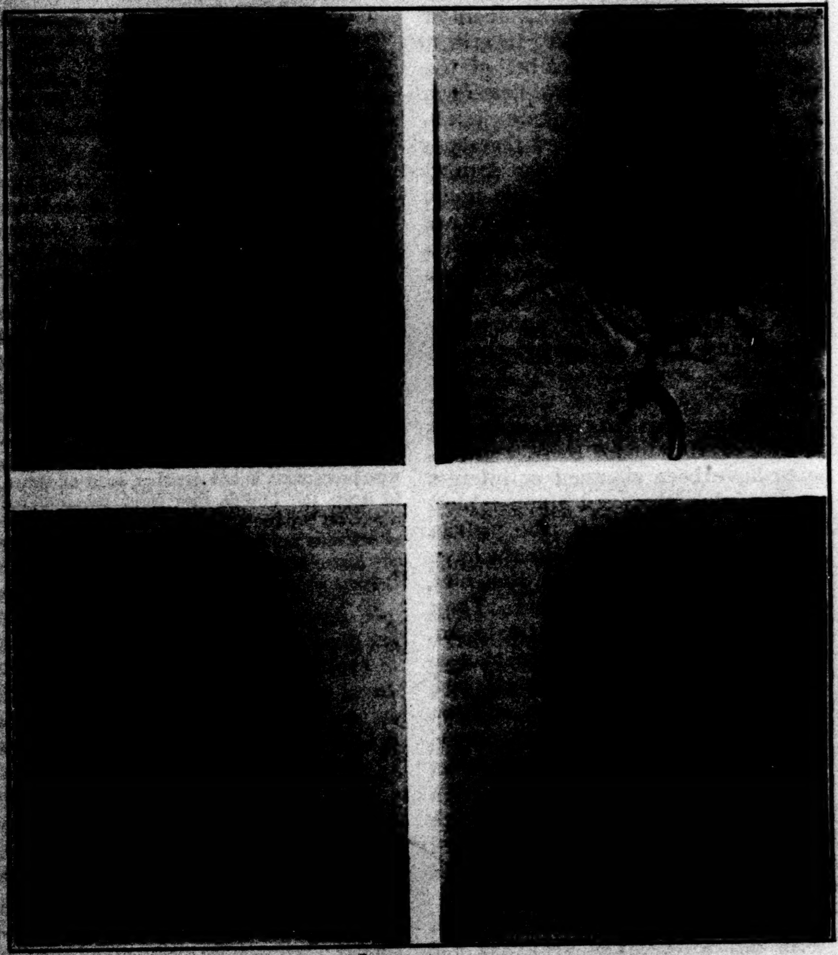
Bleeding from the larynx, esophagus, stomach and intestines cannot be controlled by local means. The patient is kept in a reclining position, reassured as much as possible, and given large doses of morphin. General supportive treatment, such as saline, subcutaneously or by infusion, external heat, and general treatment for shock, is also instituted. While the nurse is not expected to give all of these measures, she must know what the probable treatment will be and have the necessary equipment and solutions ready.

A second emergency is that due to the pressure of the growth on the trachea and the consequent shutting off of the air supply of the lung. This can only be relieved by tracheotomy. Here again the nurse must be able to recognize the approach of the emergency, be thoroughly familiar with tracheotomy procedure, understand and have ready the necessary equipment, and be ready to assist if necessary.

The radium reaction from which most patients suffer is scarcely an emergency. It is represented by a most unpleasant group of symptoms. There may be gastric disturbance irrespective of the area involved, with nausea, vomiting, and headache. Sodium bicarbonate is given by mouth with some relief; often gastric lavage is necessary. There may be diarrhoea and generalized pain and aching. Locally there is sloughing of the radiated tissue if the cancer is near an open surface. Treatment consists of the irrigations described before. Marked mental depression is frequently a sequel to radiation.

Mental depression, apart from that actually due to radiation, is often one of the ills from which these patients suffer most acutely. It is not due alone to the fact that they know they have cancer because frequently they do not. It seems to "go with" the disease just as loss of weight, anemia, and a general lowering of vitality do. The patient brings this depression into the hospital with him, and the conditions of his treatment do not allow him to lose it at once. Unlike the usual surgical patient whose recovery quickly follows operation, the cancer patient responds so slowly to operation or treatment that often he believes himself to be growing worse instead of better. Again, since cancer is a recurrent disease, there is often the added worry about finances. The frequent visits to the hospitals make inroads on his income and his financial worries become very burdensome. For these reasons the nursing care of the cancer patients is one of the most difficult and challenging fields of nursing, requiring of the nurse not only great technical skill and intelligent observation of physical signs, but ability to understand and deal with the patients' mental ills as well.

At a New York hospital devoted to the care of cancer patients the nursing care given extends into the patients' homes. All members of the Social Service staff, except the secretarial force, are nurses, and four of them



LARYNGOTOMY

(1) Incision without laryngotomy tube. (2) Laryngotomy tube in place.
(3) Tube and partial dressing. (4) Complete laryngotomy dressing.

spend all their time giving care in the homes. Every patient discharged from the hospital or coming into the clinic is given a "follow-up" date for returning to the clinic. If any patient fails to appear on that day an attempt is made to get in touch with him by telephone, and if he cannot be reached, or if there has been some sudden change in his condition, the nurse makes a home visit. The city is districted, each nurse has her own district, and comes into the clinic only once a week.

The work of these visiting nurses is to supervise patients who are caring for themselves, to teach members of the family to give care, or to give it themselves when no member of the family is available, to give dressings, irrigations, douches, colonic irrigations, and the like. When these patients need narcotics, it has seemed best to leave a supply in the house which may be taken by mouth rather than to depend on their being given by hypodermic. The nurse cannot always plan to be in a house at regular or definite hours to give the hypodermic, and if she is delayed the patient suffers needlessly.

The specialization of the nursing care of cancer patients is new and interesting. Heretofore these unfortunates have been shunned or interest was lost when the word "inoperable" was mentioned. Now the whole picture has changed. Patients have learned that cancer is not a disease of which they must be ashamed. They have also learned to seek treatment in the earlier and more hopeful stages. The span of life is being lengthened and suffering reduced. The outlook for many patients is not entirely hopeless. Because of this there is a definite field for nurses in the care of these patients, and much of their happiness and comfort depends upon the skill and understanding with which that care is given.

Vacation Hints

OCCASIONALLY we hear of heat exhaustion or sunstroke as a result of too long exposure to the hot sun or excessively high temperature. As these present two entirely different symptoms, one who is giving first aid should watch such victims carefully to distinguish between the two, as the treatment differs.

Heat exhaustion shows itself by depression, weakness, intestinal disturbance, paleness of the skin with cold, clammy feeling. Such a victim needs heat stimulation and should be moved at once to a cool spot. If the temperature is low, the patient should be kept warm.

Sunstroke has similar symptoms of giddiness, headache, and depression, but the skin instead of being pale is hot and flushed, and the temperature may rise rapidly. Such a patient needs ice cold applications, the body being rubbed with ice or placed in a tub of cold water until the temperature is lowered.

In either case a physician should be sent for at once, as heat stroke may end fatally and quickly unless medical aid is given immediately.

It is thought that the intestinal disturbance accompanying heat stroke is due to accumulation in the body of poisons from digestion which have failed to be eliminated. So it is a wise precaution in hot weather, as at all times, to keep the bowels free from accumulated digestive products, and to drink more freely of water when one is exposed to the hot sun or high temperature.—Connecticut State Department of Health, Vacation Hints No. 5.

Dr. Wynne's Ten Hints on Healthful Swimming

ALWAYS wait two hours after eating before going in swimming.
Never eat anything immediately after leaving the water.
If tired or perspiring do not enter the water.
Fifteen minutes is long enough for an average swim.
Always take a shower or bath, without soap, after dip is over.
Number of daily swims must be limited to practice and weather conditions.
People with poor circulation should swim only under doctor's orders.
Between 11 a.m. and 4 p.m. are hours best for swimming.
Plunge into water so that the entire body is wet at once.
Avoid chilling after a swim—don a beach robe after dip.

—From the Health Department of New York City.

Spinal Anesthesia

WALTER D. LUDLUM, JR., M.D.

SPINAL ANESTHESIA is not a new form of anesthesia, having been discovered forty-five years ago, and being used extensively during the last thirty years. Yet only lately has the medical profession at large been convinced that this method is no longer in the experimental stage and that its benefits are open to all. A much improved technic, new preparations of the anesthetic drug, and a better understanding of the physiologic reactions to its use, have made it a safe and thoroughly satisfactory anesthesia and have led to its recent general acceptance throughout this country and the world. As it is now so commonly used, as the nurse's relation to it is so intimate and important, she should thoroughly understand the theory upon which it is based, the technic now used, and the precautions for its successful accomplishment.

If an afferent (sensory) nerve is exposed, either at its termination or along its course, to a sufficient concentration of an anesthetic agent such as novocain, its power of transmitting sensation will be lost. To produce a local anesthesia the drug is injected at the termination of the nerves. To produce a regional anesthesia the drug is injected at some point along the course of a sensory nerve. Spinal anesthesia is a special form of regional anesthesia. The anesthetic agent is introduced into the subarachnoid space, the space between the spinal cord and its membranes which contain the spinal fluid. Here it mixes with the spinal fluid and bathes the sensory nerves as they join the spinal cord. The nerves in contact with a sufficient concentration of the drug become blocked and the parts of the body which they supply lose all sensation. The drug does not in any way directly affect the cerebrum, so consciousness is not lost. Motor nerves are less easily blocked by the drug than sensory nerves. Hence the power to move certain parts of the body may remain after they become insensitive.

The technics for inducing this anesthesia are many. In fact no two anesthetists induce it in precisely the same way. The principles, however, do not vary. The patient either sits on the operating table with his back well arched toward the anesthetist who stands behind him, or he lies on his side with his arms clasping his knees in the usual lumbar puncture position. The anesthetist prepares an aseptic field covering the middle and lower back, and protects it with sterile drapes. He has on a sterile tray the following paraphernalia: two syringes, 2 cc. and 10 cc., of a type to fit one lumbar puncture needle of fine gauge (19), one hypo needle, one larger needle for aspirating and mixing solutions, an ampule of the anesthetic drug, and a 2 cc. ampule of novocain for skin anesthesia, preliminary to the lumbar puncture.

The anesthetist determines the space between the spinous processes of the vertebrae suitable for this anesthesia and, with novocain in the 2 cc. syringe, makes a skin wheal. The lumbar puncture needle is introduced at this site until it punctures the membranes of the cord and enters the subarachnoid space. The stylet is withdrawn. Spinal fluid should drop freely. It is permitted to drop into an ampule containing the crystalline drug, or else it is collected in the 10 cc. syringe and mixed with a special preparation of the drug in solution.

Whichever method is followed a 2 to 3 cc. solution of the drug is collected in the 10 cc. syringe and the syringe attached to the lumbar puncture needle. Spinal fluid is aspirated until sufficient has been withdrawn to carry the anesthesia as high as the anesthetist desires. The mixture is then injected with moderate force and the needle is withdrawn. The patient is promptly placed in proper position for the operation.

Obviously before injecting this drug, one must know approximately how far it will diffuse toward the head in concentration sufficient to produce sensory nerve block. The anesthesia is not a complete success if it produces a much larger area of insensibility than necessary or if, on the other hand, it does not extend sufficiently high to thoroughly anesthetize the field of operation. If the anesthesia is too extensive the patient undergoes unnecessary risk. If it is not extensive enough, a general anesthesia has to be resorted to.

The anesthetic drug is ordinarily introduced into the subarachnoid space low in the spinal column—usually in the lumbar region. How far it progresses toward the head depends upon several factors—the height of the spinal puncture, the dose of the drug, the amount of spinal fluid removed, the force of injection, the position of the patient.

It might be said that this is the anesthesia of choice for any operation below the diaphragm in which local is not entirely satisfactory, with certain very definite exceptions. The contraindications are few, but very definite. Any marked involvement of the cerebrospinal nervous system should exclude it. Cases in severe shock would do better with the stimulation of gas. A spinal puncture in a case of septicemia offers a portal of entry to the meninges with great risk of meningitis. Patients with extreme cardiac decompensation do not stand well further cardiac and respiratory embarrassment such as sometimes accompanies spinal anesthesia. Suppuration at the site of puncture excludes this method.

Inhalation anesthesia should be eliminated and spinal anesthesia used in any case of pulmonary tuberculosis, healed or active, which requires an operation to which this method is applicable. Similarly, in the aged or debilitated, in those suffering from cardiac, nephritic or endocrine diseases, spinal anesthesia is preferred because it causes far less metabolic disturbance than even the least toxic of the inhalation anesthesias. In emergency operations, where the patient comes to the operating room with a full stomach, this anesthesia is particularly desirable because it is unlikely to cause nausea and vomiting, and if they do occur they do not interfere with the anesthesia. The coöperation of the patient during an operation is often a considerable aid and can be had with this anesthesia. (A cough reveals the sac of a hernia during a herniotomy, etc.)

Such special preparation of the patient as this anesthesia requires is largely psychic. In this preparation the nurse can be of unusual assistance to the surgeon. The anesthesia is commonly enough used that it may be treated as in no way novel. Nevertheless, many patients will make inquiries about it. A well informed and tactful nurse can allay apprehension by easily comprehended replies. If he inquires, the patient is told that there is no sensation whatsoever in the operative area. His eyes are covered during the operation, he can converse with those about him, can drink if he wishes and be entirely at his ease.

Soon after his return to bed, a light meal may be eaten. The distress of nausea and vomiting, restlessness and excessive perspiration, which follow general anesthesia, will be eliminated. Fear of the lumbar puncture is easily dispelled by explaining that there is the merest needle prick. Such conversation reassures the patient who begins to take fright as the hour of operation approaches, and confirms what the surgeon has already said. One-half to three-quarters of an hour before the operation, sufficient narcotic is administered to prevent undue psychic stimulation.

During the operation the nurse again has a big part to play. She sits at the head of the operating table and converses with the patient in a low tone. To distract him from the procedures in the operating room, to comfort him and to hide the scene from him, iced wet towels are applied to his forehead and over his eyes. The operation is alluded to as little as possible. An occasional drink may be given. The conversation of the doctors and the other nurses and attendants in the room is subdued, and guarded as to subject. Everything is taken as a matter of course.

Meanwhile the nurse observes carefully the depth of the respirations, whether they are labored or not, the rate and quality of the pulse, the patient's color, whether he perspires freely or not. Collapse, in the rare instances when it occurs, is preceded by definite symptoms. The patient's replies to conversation or queries become short, labored; respirations are slow and show effort; the pulse rate drops markedly, its volume diminishes; he breaks out in profuse perspiration, his skin feels clammy. These changes occur rapidly. The nurse must always be on the lookout for them. They are easily combated by increasing the Trendelenberg position and, if necessary, starting an intravenous infusion. The nurse's responsibility is, therefore, heavy.

When the operation is completed the patient is carefully transferred to a stretcher, transported to his room, put into a bed the foot of which is raised on shock blocks. During transportation he must be observed as carefully as a patient who has had a general anesthetic. If the operation has been of short duration the anesthesia will still be at its height and there is considerable danger of the patient being thrown into shock. This is also true if the operation has been particularly severe. Sudden changes of position increase this danger. The patient should, therefore, be lifted from table to stretcher and stretcher to bed as gently as possible and the stretcher raised to the Trendelenberg position on the slightest symptoms of shock.

If the operation itself does not contraindicate it, the patient may have fluids by mouth immediately on return to the room. A stimulating drink, such as coffee or whiskey, is particularly good. Soft diet may ordinarily be given the day of the operation and soft and regular diet the next day. Shock position is maintained at least twelve hours as prophylaxis against the postoperative headache which occurs in about one out of fifteen patients. If the headache should occur in spite of this, the blocks should again be placed under the foot of the bed and the patient be cautioned not to raise his head above his hips for at least twenty-four hours. Soreness in the region of the lumbar puncture wound, or lumbar backache, is easily controlled by aspirin or phenacetin.

Transportation of Patients after Spinal Anesthesia

MARGARET NORRIS, R.N.

FOR the transportation of a patient who has had a spinal anesthetic and for whom the surgeon has ordered that his head be kept lowered for a certain number of hours, I have devised a support which, placed under the mattress pad on the stretcher, maintains the patient at an angle of ten degrees until he is placed in bed.

This support, which resembles an inclined plane, is 48 inches long, 18 inches wide, slopes from a height of ½ inch to 8½ inches. It is made of half-inch lumber and is painted white, so it is neither heavy and cumbersome to handle nor unsightly. It is placed on the stretcher and taken off according to our needs, and may be stored in a small amount of closet space. Any carpenter can make such a support at a minimum amount of expense, and the dangers of bad results from a spinal anesthetic are greatly reduced by keeping the patient in the same position until fully recovered.

Lactobacillus Acidophilus Therapy

KATHERINE E. LORENZ, R.N.

MAN'S first drink is milk. It remains a staple article of diet throughout his life. It has been subjected to much modification that it might be more pleasing to the taste of man. The souring of sweet milk was one of the first and simplest methods used extensively. Even the Bible makes frequent mention of its use. The sour milk therapy has undergone various modifications, but none of these are so striking as the development of the therapy of Lactobacillus acidophilus.

No doubt, too much has been claimed for sour milk therapy, yet there is evidence that B. acidophilus culture may be employed in such a way as to have therapeutic value, especially to relieve constipation and diarrhea, by changing the intestinal flora.

In a few cities acidophilus milk may be purchased for about fifty cents a quart. However, by observing a little care it may be prepared in the home or hospital at a very low cost.

To Prepare Acidophilus Milk

UNSWEETENED evaporated milk is particularly suitable for this purpose, and may be obtained from the grocer at a fair price. For a starter, a pure broth culture of B. acidophilus may be obtained at most drug stores. The acidophilus organism grows best at 90 degrees to 100 degrees F.

1. Clean a quart thermos bottle by allowing it to stand overnight full of water containing household ammonia; then scald it.
2. Place a cork, a can-opener, and a thermometer in a pan and pour boiling water over them. (Be sure you have a thermometer which will stand boiling water.)
3. Wipe the top of a one-pound can of evaporated milk free from dust, and pour boiling water over it. Open the can and pour the contents into the pan that has been scalded. Fill the can with boiling water and pour into the evaporated milk.
4. Put the pan in cool water, and stir the mixture with the thermometer until the temperature has come down to about 105 degrees F.
5. Add two or three ounces of commercial L. acidophilus culture, mix, and transfer to the thermos bottle. The temperature should now be about 100 degrees F.
6. Cork, and let stand for twenty-four hours, or until the milk has acquired a pleasantly sour taste.
7. Transfer to a clean milk bottle, and place in the refrigerator.

Succeeding cultures of acidophilus are prepared by using about a teacupful of milk culture, previously made, to inoculate the diluted evaporated milk for the next run.

If the milk is kept in the refrigerator, it should be consumed within forty-eight hours, for the reason that the organisms rapidly die out at such a low temperature. If kept at room temperature, it should be consumed within twenty-four hours, or a considerable increase in acidity may be expected.

Typical acidophilus milk has a fine grained curd. It is rather viscous, especially at low temperatures, but not stringy.

The nutritive value of this product is exactly the same as that of whole cow's milk. Evaporated milk is whole cow's milk evaporated down to one-half of its bulk. Therefore, by diluting a can of it with an equal amount of water, the composition will be the same as normal cow's milk.

Dosage and Result of Treatment

THE type of Lactobacillus acidophilus treatment varies with different individuals, and is dependent upon the condition to be treated.

In cases of constipation, the average daily dose of Lactobacillus acidophilus milk is 1,000 cc. of culture containing about 200,000,000 viable Lactobacillus acidophilus per cubic centimeter.

Lactobacillus acidophilus milk, when given for the first time, causes the formation of considerable gas. For this reason it is best to give 500 cc. the first day, 750 cc. the second day, and 1,000 cc. daily thereafter. Fifty grams of lactose are added on the third day, and the dose is increased, 50 grams each day, up to 300 grams per day. This dose of 1,000 cc. of acidophilus milk and 300 grams of lactose usually produces a good response within two weeks. In mild cases of constipation the dose may be diminished. Sometimes 100 grams of lactose daily, with 1,000 cc. of acidophilus milk once a week, or even less frequently, is sufficient. In more severe cases of constipation the dosage of milk may be increased to 1,500 cc. per day, and the lactose to 400 grams. Another practice that has proved valuable in difficult cases is the use of a high enema of acidophilus milk, thinned with a small amount of warm water.

Patients who previously average not more than one normal defecation per week have normal defecations almost daily as a result of treatment.

In diarrheal cases, the average daily dose of acidophilus milk is 1,000 cc. the same as in constipation. Lactose is contraindicated in diarrhea and is therefore omitted. In more severe cases which do not respond very readily to treatment, an enema of 1,000 cc. of acidophilus milk thinned with warm water may be given in addition to the oral administration.

Fewer defecations per day, and the feces more solid in consistency, as well as lighter in color, may be noted as a result of this treatment.

Lactobacillus acidophilus tends to transform the human intestinal flora from one that is Gram-negative and proteolytic to a Gram-positive fermentative type. The transformation of the intestinal flora from a Gram-negative to a Gram-positive type is a guarantee of the alleviation of constipation. It will be seen that, with only a few exceptions, there is an increase in the number of normal defecations where the intestinal flora are transformed as compared with the period before treatment.

It is advisable for the patient not to use cathartics of any kind during Lactobacillus acidophilus treatment. Enemas and suppositories may be used for relief when necessary.

Patients suffering from hyperacidity are rarely good subjects for lactobacillus acidophilus therapy; but in children's intestinal complaints it has proved very satisfactory, especially in the summer diarrheal cases.

Acidophilus Milk as a Food

ACIDOPHILUS milk is a food and not a drug. During Lactobacillus acidophilus treatment a change in the diet is not essential. The addition of so much milk to the usual daily diet will naturally interfere with the appetite. However, the nutritive value of this milk and the caloric value of lactose are so high that there need be no fear of lack of nourishment during acidophilus feeding. It is best to give divided doses of acidophilus milk as nearly midway between meals as possible so as not to interfere with the appetite any more than necessary. Usually patients will gain weight on acidophilus milk and lactose.

Striking as the results are, acidophilus milk is no remedy for all ills, nor will it prolong life as Metchnikoff hoped. Also Lactobacillus acidophilus therapy is not more efficient in relieving constipation and diarrhea than is the usual medical treatment, but it is a simple treatment and works no hardship on the patient.

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Contraindications to Vaccination

"IN general, skin diseases, particularly eczema, are the only conditions which will justify school attendance and at the same time be contraindications to routine vaccination. This is on account of the danger of diffuse vaccinia from carrying the vaccine into the open lesions of the skin disease, or the danger of contaminating the vaccination site if the skin lesions are purulent. Patients with such diseases as tuberculosis are in no wise harmed by properly performed vaccination. Acute infectious diseases may cause a vaccination 'take' to be delayed or atypical, but are not in themselves contraindications in case of possible exposure to smallpox. There is a curious relation in leprosy which tends to cause the lighting up of leprous lesions during the course of the vaccination, but which may promote more rapid healing thereafter. Serious lymphomatous diseases, including lymphatic leukemia, may be made worse by vaccination. Neither pregnancy nor any age, from 1 hour to over 100 years, is a contraindication to vaccination if smallpox is in the community.—*Weekly Health Bulletin,* Connecticut State Department of Health.

The Minimum Standard (Tentative) for Official Registries Recognized by the American Nurses' Association[1]

Foreword

The need for a simple set of standards for the conduct of official registries has been felt increasingly in the American Nurses' Association for several years. At the present time registries occupy a particularly significant place in the work of organized nursing for the following reasons:

First, the function of the official registry is being reinterpreted.

It is no longer only a coöperative employment agency for nurses. In many places the official registry has enlarged its activities so that it is now virtually a community nursing bureau, working closely with other nursing and health agencies in meeting the nursing needs of the community.

Second, the economic maladjustment of the private duty nurse, with her long periods of inactivity and her low living wage, has centered the attention of nursing on the official registries as distributors of private duty nursing service. The national organization is watching with interest and encouragement these experiments being conducted in the official registries of several cities, in an effort to bring about a more equable distribution of private duty nursing service.

The following requirements are submitted at this time as a purely tentative minimum standard for official registries. It is desired only that this shall serve as a point of departure. As the study of official registries now being conducted by the American Nurses' Association progresses, and as newer knowledge of registries is gained, it is to be expected that revisions and adaptations will be made in the minimum standard as now presented.

THE minimum standard in registries is based upon the premise that there are certain fundamentals in physical equipment, in organization, administration, and objectives, common to all official registries of the American Nurses' Association, whatever their type of organization, their size and their scope of function.

Based upon these fundamental requisites for an official registry, the following six sections, comprising the minimum standard, are presented herewith:

I. Physical plant
II. Organization
III. Administration
IV. Registrants
V. Records
VI. Facilities for growth

I. *Physical Plant*

An office for the conduct of the official registry should be maintained in a business location where a twenty-four hour service (light, heat, elevators, telephones) is available.

The site shall take into consideration accessibility for registrants, as personal interviews between registrar and registrants are desirable and to be encouraged.

For the best interests of all concerned, it is urged particularly that the registry shall not be conducted in a private home, although limitations in funds and personnel often make it necessary to establish a registry in a home during the early period of its development.

II. *Organization*

(a) The official registry shall be conducted under the auspices of an association or associations which are component parts of the American Nurses' Association.

(b) The composition of the board of directors of the official registry may be as follows:

1. A board of directors composed of nurses, in good standing in the American Nurses' Association, plus representatives of other constructive community interests,

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[1] Presented at the biennial convention of the American Nurses' Association, June, 1930.

those to be appointed as feasible by the nurse members of the board.

or 2. A board of directors composed of nurses, all of whom shall be in good standing in the American Nurses' Association. If sponsored by a district association, all nursing interests in that community shall be represented on this board.

or 3. A board of directors composed of nurses in good standing in the American Nurses' Association, with an advisory committee composed of representatives from medical, hospital, and lay groups concerned in community health.

(e) Meetings of the board of directors of the official registry shall be held at least once a month as provided in the rules and regulations.

III. *Administration*

(a) Minimum rules and regulations for the official registry shall be those recommended by the National Committee on Registries and approved by the Board of Directors of the American Nurses' Association.

(b) Program. The program of the official registry shall be planned to meet those community nursing needs which legitimately fall within the province of the official registry in that community. Two major objectives shall be borne in mind particularly:

1. The program shall be designed to answer the nursing needs of that group or groups which at the time are not receiving adequate nursing care, at a price commensurate with their ability to pay for the service rendered.

2. The program shall be arranged to utilize all possible facilities in studying and trying to solve the economic problem of the private duty nurse group.

(c) Policies. Policies of the official registry shall take into consideration the ethical and working relationships of the registry

1. With reference to the obligations of the registry and its possible function in a unified community health program;

2. To its registrants, by maintaining, safeguarding and furthering their best interests;

3. To the medical profession;

4. To other health and social agencies.

(d) Personnel. The personnel of the official registry shall include

1. Registrar (sometimes called Director), to be appointed by the board of directors of the registry for such a period as is designated in the rules and regulations of the registry. She shall be a member in good standing in the American Nurses' Association, qualified to perform the duties incumbent upon her office. It is particularly necessary that she shall be employed on a salary basis.

2. Office Staff. The office staff of the official registry shall be adequate to conduct the business of the registry in an efficient and desirable manner, twenty-four hours a day, seven days a week. Twenty-four hour duty on the part of the registrar, or any member of the registry staff is to be avoided, and countenanced only as an emergency measure.

IV. *Registrants*

(a) Registrants in the official registry shall include those persons qualified to give the kinds and amount of nursing care needed to fulfill the functions of the registry in the community. Registrants may be

1. Registered nurses, to give nursing service on a case or on an hourly basis. It is recommended that all registered nurses carried by the official registry shall be members of the American Nurses' Association.

2. Undergraduate nurses, and

3. Practical attendants, both groups to give bedside care where skilled nursing service is not needed, and to assume necessary household obligations.

(b) Responsibility of the registry for its registrants shall include the following:

1. Credentials of the registrant shall be considered and approved by the board of directors of the registry.

2. Essential information regarding the qualifications of the registrant shall be available for presentation to the patient or his family when the nurse reports for duty. The nurse is to be encouraged to show these essential facts regarding her

professional qualifications to the patient and doctor in order that they may have full knowledge of the type of service to be expected of her.

(c) General supervision of the registrant by the registrar shall be provided as deemed necessary or desirable by the board of directors of the registry. Closer supervision is necessary in an hourly service. It is required also wherever undergraduate nurses and practical attendants are carried by the registry. Supervision in the latter cases should be not only in the registry but in the field.

V. *Records*

Minimum requirements for recording the assets, costs, activities, and accomplishments of the official registry shall be

(a) Personal Records for Registrants. Personal records shall be kept for all registrants, the information being given by the registrant in person at the registry. Where personal registration is impossible, the registrant shall appear at the registry before entering upon her duties.

Personal Records shall include the following:

1. Application of Registrant

Registered Nurse

(a) Name, address, telephone, age, weight, height, physical defects, religious affiliation, passport picture.

(b) Credentials:

1. School of nursing.
   General outline of course.
2. Postgraduate work.
3. Registration (states in which registered).
4. History of experience, to include registries of which the registrant has been a member and positions held previously.
5. Professional organizations of which she is a member.

Undergraduate and Practical

(a) Name, address, telephone, age, weight, height, physical defects, religious affiliation, passport picture.

(b) Credentials:

1. Preparation and training.
2. History of experience, to include registries of which registrant has been a member and positions held previously.

2. References: at least two as to character and professional ability.

3. Signature to statement appended to application blank, promising to abide by and promote the best interests of the registry and of the nursing profession.

(b) Registry administration records. Records necessary in the administration of the official registry shall be those which

1. Make it possible for the registry to carry on adequately and effectively its daily work.

2. Give information of statistical value in computing costs and measuring work and accomplishments of the registry over a given period of time.

3. Give the basic machinery (which need not be onerous or costly) for expanding and recording the expansion of future activities and developments in the registry as they are related to registrants, conduct of the registry and nursing service given by the registry in the community.

VI. *Facilities for Growth*

(a) As the growth of the registry depends upon the service it renders, its effectiveness lies in adequately developing the fundamental principles in registry standards as heretofore outlined. Moreover, its progress will depend equally upon those qualities of sincerity and good faith which result in inherent confidence and in happy human relationships with all persons and groups involved.

(b) Conferences for registrants shall be held at least once each month, an invitation being issued for them to attend. Programs for these meetings shall be planned as a unified course of instruction. They shall be practical and technical in nature, and those for registered nurse members of the registry shall be planned not to conflict with those conducted by the association under the auspices of which the registry is conducted. Rather, the registry conferences shall suggest and augment the other program.

(c) At regular intervals registered nurse members of the registry shall review their professional activities, pooling and analyzing their experiences for their mutual benefit and help, thus forming a basis upon which to point the line of the future growth of the registry. The official registry is a coöperative enterprise and it is only through coöperation that it can develop.

(d) The official registry shall aid, foster, and develop as much as lies within its power, such educational opportunities afforded by the community as may be of use to the registrants in their personal growth, and shall encourage the registrants to use these educational facilities for their own advancement, and for the promotion of the best interests of the registry.

Consideration of Proposed Registry Standards[1]

CASSIE J. ROGERS, R.N.

IN opening this discussion let us first define some of the terms as used here:

I. Registry—A place where a register of the nurses available for duty is kept and these nurses placed.

II. Standard—That which is established by authority, custom, or general consent as a model or criterion.

The oldest nurses' registries were for the most part organised by a group of nurses or an alumnae association to serve their own group and be a clearing house for maintaining their service to the community. Beside this, there was the custom of a medical practitioner maintaining a list of nurses, with whom he was acquainted, in his office from which he filled his calls for nursing service. This practice still exists to some extent.

For the purpose of this discussion, let us define private duty as the bedside care of the sick of the community, for which the public is able to pay on a part- or full-time basis. This part-time basis is usually spoken of as "hourly nursing."

The private duty or full-paid service belongs to the private duty nurse, and in all fairness should be left open for development to meet the community needs and a greater field of service for these nurses. Of course, one realizes that this could not hold except in densely populated areas, as each community has of necessity to formulate a registry plan to meet its own community needs as nearly as possible under the restricted funds available, and in many instances with an inadequate supply of nurses to meet its needs.

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[1] Read at Registry Round Table, No. 2, Milwaukee, Wis., June 12, 1930. General topic: "Administrative Policies and Registry Programs."

An official registry is one sponsored by an organized body of nurses, a part of the state and national organizations, and as such some requirements or plan must of necessity be set up, on which the organizations may place their seal of approval.

These plans may not be perfect, but they are a beginning and show progress toward meeting an obligation to the public and to the nurses. There must also be some degree of uniformity in the registries upon which the organization places its seal.

These minimum standards are the outcome of a survey of twenty registries of various types, made by the A. N. A. Headquarters Staff, as a result of the many letters of inquiry and in some cases dissatisfaction coming in to Headquarters office.

The six fundamental requirements we shall consider as follows:

1. The ideal plant or site for an office cannot be met by all registries, but it is a goal to reach. Lack of funds prevents this and the need for a small amount of service.

2. Organization is the machinery set up for the deciding of the policies of the registry and on any change in program or field of service. The section of the machinery entrusted with the supervision of membership, rules, personnel choice, ethical problems and investigation of discussion and settling of complaints from doctor, patient, and nurse should be made up of nurses.

If a broad program of community service is sponsored, an advisory committee or lay group may be added representing community welfare groups or interested lay members.

3. Administration is the method and personnel entrusted with carrying on the routine business of the registry.

4. Registrants—an adequate supply of well qualified nurses to meet the community needs.

5. Records should be accurate, simple, and contain accurate knowledge of registrant and her qualifications such as would aid in her placement.

6. Facilities for growth should exist and the organizations should be alert to find new fields of service to the community and for the nurse, but a registrant should never be sought until there is a field for her services.

I say this, as I fear there is a tendency to advertise official and other very large registries out of the city and state in which they operate, often bringing an added number of nurses into an already overcrowded field. According to the A. N. A. survey, the calls to one large registry average one hundred per day. Multiply this by thirty and we have three thousand calls per month. The report does not state, but let us say for sake of argument that this is the largest registry with over two thousand members. This gives us one and one-half calls per member per month. The last year has shown a comparatively large number of calls to cases of short duration. The facts are plain to many nurses in such a locality and over-expansion of membership. One wonders if this condition is due to local over-production or an influx of nurses from other sources. Unfortunately, it is no fault of the individual nurse that there are too many of her at the present time.

The institutions take their quota of their graduates to meet their needs, some go into other institutions and some into the other branches of nursing service, but the largest group from each graduating class enters the private duty field. Each individual nurse has during her period of training aided in the care of the sick of the community in which her school is located and in most instances has looked forward to that community as her field of service.

Two other important phases are coöperation—this I mean in a very broad sense, between registrar, registrant, and the committee or board of directors of the registry.

The registry should be open to the

registrant at all reasonable times, where they may bring their problems and feel that they will receive an understanding interview on any professional problem, and for the young nurse, if she may bring her personal problems, it is ideal. This last is much more likely to be found in a small or medium sized registry.

The registrant should be made to feel that in coming to the registry for advice, she is always welcome as it is her service bureau.

The committee or board of directors should be accessible and willing to listen to both sides of all complaints and, after having made every effort to get an accurate picture of the problem and its background, decide each case on its individual merits. No set rule can be made for adjustments. This group, entrusted with registry policies, should be willing to receive suggestions from the group of nurses who finance the registry and whom they are organized to serve.

The registrant should be willing to coöperate in an effort to make her registry stand for the highest in ideals and service to her community, but she is unlikely to be amenable to discipline regarding the type of case or time of service, day or night, which she chooses.

It is seldom a nurse chooses a type of service without there being a definite reason, in that she feels better qualified to do that type of nursing, or length of service has made her physically unfit to meet the demands of some types of cases. An institutional worker chooses her service, either executive, operating room, ward supervisor, etc., why not allow the private duty nurse the same privilege? In case of unfilled calls, a nurse can usually be found whose loyalty prompts her to meet the demand on her registry without exacting it by disciplinary rules.

The method of financing should be governed by the policies of the registry. If a broad program is to be maintained, including placements for institutional positions, etc., a spirit of fair play demands that other groups receiving service should pay some amount toward maintaining machinery for this service rather than a small amount for each placement. This method does not meet the routine expenditures for this service unless there are a large number of placements.

The last and one of the most important requisites is the chief registrar or director. By this I mean the person or persons making the contacts, personal and by telephone, with the public, medical profession, and registrants, and answering and relaying the calls. If she antagonizes any of these groups by personality or attitude, the registry cannot measure up to a high standard of service. Of all the executive personnel, she should be the most wisely and carefully chosen.

In closing let us sum up some of the requisites necessary for a successful registry as follows:

1. Community need.
2. Well qualified nurses to give the service required by the community.
3. Registrar who meets professional and personality requirements and preferably one who has had private duty experience as well as experience in other nursing fields.
4. A committee or board representing all types of nursing service.
5. Equipment, by this I mean housing and adequate facilities to carry on the routine business.
6. Last but one of the most important, a spirit of coöperation, understanding and good will between all groups involved.

I have not touched the problem of the practical nurse on the registry, as I feel that so long as she receives no definite training and there are no definite qualifications or standards for this group it should not be sponsored by a professional group.

Essential Record Forms in Registry Operation[1]

LUCY LAST VAN FRANK, R.N.

IN attempting to present the subject assigned to me, I have no intention of advancing ideas, but to say as simply as possible how we have worked out records in our Chicago registry with some degree of satisfaction.

The growth of registries has made systematic record-keeping a physical and economic necessity. They have progressed from a small group of registrants to hundreds. The pet systems many of us set up at the beginning soon proved inadequate. Expansion demands quarters and we seek ways and means to meet the present need and provide for future growth.

I feel sure many registrars have realized, as I have, that unless a central registry can give a better service to the hospitals than they secure themselves, there can be no particular advantage in relaying calls through an outside source. A registry must prove itself, sometimes through many years of service, before hospitals are convinced the registry can do a better job. For this reason we must be alert for improvement.

The success of registry administration, then, depends largely upon the scheme worked out to convey information at a glance. We cannot afford to grope around for it while someone is waiting at the telephone for an answer.

Registry records are still in the making and no general policies regarding them have been agreed upon. Aids to quick and ready use should be kept in mind and the simpler, the better.

Experience has demonstrated the need for the following in compiling and maintaining registry records: application blank, rules and regulations, training school blank, work or personnel card, case records, daily record sheet, receipt blanks, ledger cards and eight desk memoranda.

The application blank should gain from the applicant the information needed to answer satisfactorily any queries regarding her training, experience, and general fitness. It will be the groundwork from which to build the work or personnel card.

When we consider that many registry assistants have no opportunity of personally meeting those whom they are daily assigning, it indicates a need not only for a word portrayal, but a photograph of the nurse as well.

I remember years ago when I suggested this as an aid to more intelligent service it was frowned upon as of somewhat questionable ethics. In a large registry without such assistance to answer questions regarding physical appearance which are sometimes put to us, we must continue to stumble along. Physicians and the laity expect us to have personal knowledge of nurses we send them. It is gratifying to know that this point has been recognized in the recent report made by our national association in its study of registries.

Hand in hand with the application blank go the rules and regulations which the nurse should read before filling out the blank. They should be as brief as possible, setting forth the object, management, eligibility, amount of dues, and a statement of registry policies which directly concern the nurse in relation to her obligations toward the registry.

Next comes the training school

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[1] Read at Registry Round Table, No. 2, Milwaukee, Wis., June 12, 1939. General Topic: Administrative Policies and Registry Programs.

record which is our most valuable contribution to registry records. To ensure its prompt return, a stamped addressed envelope is provided.

In seeking the quality of clinical work, adaptability, conduct and personality I have found it advisable to be as brief as possible. A universal vote of thanks is due to all those busy directors of training schools who, through so many years, unceasingly and uncomplainingly fill in these registry blanks. Also we place a great responsibility on them, for often the acceptance of a nurse is based on this report. In fact, I believe most of us agree it is the most reliable information we obtain and is usually deemed sufficient, especially when the nurse confines her work entirely to her own hospital. If she has had a varied experience since graduation, then it is well to send to former employes for a report, using a blank similar to the training school form.

With all this information completed, we are ready for the work or personnel card, which is our outstanding record. It is generally conceded in all good business conducted entirely over the telephone that a visible record system of one form or another is the most practical. There are many of these on the market, but none to my knowledge which meet every need for registry work.

The expense involved in changing equipment is apt to deter many from venturing on untried systems. The Acme Visible System is the one in use in our Chicago Registry with a large degree of satisfaction.

An alphabetical set-up of the entire membership is basic. On a visible line appears the information needed most, such as name, telephone, creed, school, and types of cases accepted. These cards are 4 x 6 inches, are hung on wires and are easily removed. We are at present trying out the use of a pocket on our membership file into which the card is slipped when a nurse is assigned to duty. This is with a view to using the pocket as a cross file and to save one operation in hanging cards.

With this method we have, to the left of the telephone, the register of nurses on call, with cards arranged on upright steel frames with swinging panels. Arrangement is by hospitals first and then the general list. As requests for nurses come in these cards are removed. When assignment is made, the call is recorded on the daily record sheet, the card is dated and placed in a box where they are allowed to accumulate during the day and are filed by the night registrar. To the right of the switchboard is the complete alphabetical steel drawer file, from which cards are removed when nurses are ready for duty.

We use metal, colored signals attached to the visible line of the work card to denote what the nurse is registered for, such as: white for day, black for night and red for twenty-hour duty in homes. A very helpful code may be worked out with colored paper in various designs. We have adopted these in our aim to get away as much as possible from having to read too many notations. The value of signals is that you can make them your servants. A signal is something that comes at you rather than something you have to search for. Their use gives unlimited opportunity—even the punching of holes in the cards could be employed if colors are exhausted. It is impossible to avoid some pencil notations, for nurses change their minds regarding the way they wish to register and also frequently change their addresses.

There should be a case history for every nurse, containing her applicathat blank and all written reports and letters concerning her. A good grade manila envelope has served our purpose well, containing name and school on the top and filed alphabetically.

A daily record or work sheet tells the story of each day's work and is a basis for that monthly report registrars are called upon to make.

Then there is that very important financial record. It will be found more satisfactory, especially in larger registries, to keep the registry dues separate from those of the district association. It is gratifying to know the status of each department. A receipt should always be given for all money received, stating what it is for. These should be made up in duplicate form. One ledger card for each member will suffice to record both dues, district and registry, if properly ruled.

And now, as we turn our attention to the desk, there are within reach the eight other requisites which have worked their way into use:

(a) Small memorandum book, folding back at the top, to record nurses as they report for duty or register off.
(b) Weinman Handipad to receive calls for nurses.
(c) Daily list of nurses out for a period.
(d) Calendar for recording future registrations.
(e) Hourly order blanks.
(f) Change-of-address slips.
(g) Withdrawal slips.
(h) Reinstatement slips.

One of our most important tasks is the registering of nurses. With her simple message "I am ready for duty," she is putting her interests into our hands. How are we safeguarding them? Too much stress cannot be laid on the necessity of making a definite rule for all registry workers to automatically take up a pencil every time the telephone is answered and record immediately the request. There is nothing as satisfactory as facts to stand on and to safeguard our service.

Second, a convenient handipad to record requests for nurses. The Weinman Handipad is the most practical and safest method we have found for this purpose. It is perforated in three sections, is firmly mounted, and has just enough slant to make writing a comfort. One of the three perforated slips to the sheet is ample to record data concerning the average call. When the nurse is selected, this may be slipped under the clip on the card and remain in view before the registrar until the nurse is assigned and the call recorded. The slip is then discarded. It is a safe rule to record only one call on each slip.

Third, a mounted memorandum pad to record names of nurses who are out for business or recreation each day, or some find it handier to slip an indicator on the card.

Fourth, a desk calendar to record the names of those registering for a future date. Then there are four small 3 x 5 inch pads, each a different color, printed in bold type for recording the following:

Hourly calls
Changes of address
Reinstatements
Withdrawals

These last two serve to keep lists accurate and help in arriving at membership count each month.

Justice, not only to our registrants but to those who patronize our service, demands that records be ample to supply prompt and intelligent service.

Business today has two marked characteristics—it moves fast and seems to glorify speed in all things and it is based on facts. It is the responsibility of the registry to see that these facts are always ready, accurate, classified, easy to find quickly, and certain to be in place. This must be accomplished with thoughtful carefulness which alone ensures accuracy and prevents mistakes which may be costly to others. No amount of willingness to work can overcome the defects of a record-keeping system that does not supply needed facts as speedily as they are required.

I think I can venture to say in closing that the interest shown by our Director at National Headquarters, Miss Geister, and others in our registry problems, has been a great incentive to all registries to find yet a better way.

With united effort we look for a solution of many of the "ifs," "buts," and "ands" of registry operation.

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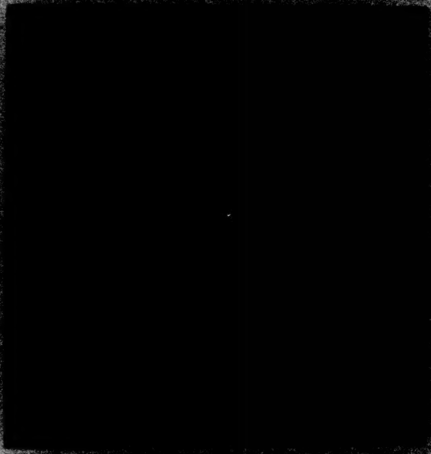
Devotion to a State Board

MARY CARY PACKARD, a charter member of the Maryland State Board of Examiners of Nurses, has resigned from active membership on this Board after an exceptionally devoted service of twenty-[illegible] years. As one of the original appointees of the Maryland State Board, Miss Packard was its Secretary-Treasurer from 1904 to 1909; and from 1909 to 1911, its President. She then retired, but in 1915 she was prevailed upon to return to her post. From 1915 to 1930, a period of fifteen years of activity and expansion in nursing education, she has been our widely known and well beloved Secretary-Treasurer. In her policies she has been both far-seeing and wisely conservative.



MARY CARY PACKARD, R.N.

Miss Packard came to Maryland from Massachusetts in 1897, a graduate of the Massachusetts General Hospital under Anna C. Maxwell, then Superintendent of Nurses. With Sarah F. Martin (Mass. Gen. 1897, now and for many years Executive Secretary of the Maryland State Nurses' Association) Miss Packard on coming to Baltimore entered upon a field of work which in retrospect we find to be the first serious effort in Maryland in Public Health Nursing. This work, with a record in its first year of 800 visits to patients with bedside nursing care, continued for several years. It developed into the Robert Garrett Children's Hospital and Dispensary, of which institution Miss Packard and Miss Martin were in charge for twenty-five years.

In the development of the nursing organization in our state, Miss Packard and Miss Martin have played an active part. They have held continuously posts of [illegible] responsibility. [illegible] on the Examining Board, Miss Packard will still [illegible] nursing interests. [illegible] of the Maryland League of Nursing Education and [illegible] membership in the Maryland State Nurses' Association.

H. C. R.

Publicity Methods and Costs[1]

EMMA L. COLLINS, R.N.

MOST of us will agree, I believe, that nursing needs to be interpreted to the public, but the word "publicity" seems to frighten us. We think it calls for an elaborate program, much expense, and a great deal of time. It also may mean simply using our ordinary resources to the best advantage.

These resources are described in interesting detail by Virginia McCormick, in her fine series of articles on "Public Information" which has been appearing in the *American Journal of Nursing* since the first of the year. I shall take it for granted that you all are sufficiently interested in nursing publicity to have read these articles, and that you believe with Miss McCormick that "the public has a right to be told about nursing" and that "the time to speak has come."

You will never have difficulty in getting publicity as long as you have something to say. A new project or the reorganization of an old one, always can get the ear of the press. And great are the uses of publicity *if* your program reaches out beyond the interests of your own group. The public will want to hear about it—not once, but often and regularly. Effective publicity is never a steady-by-jerks affair.

One of the best forms of publicity is simply being accessible. Every official registry of a district nurses' association should have an address in the telephone book which would designate it as a professional nursing bureau. Its office should be in a convenient neighborhood, and in a prominent building with other health organizations, if possible. In too many localities, nursing is represented to the public or the press, only by the busy hospital, with its diversified interests, the visiting nurse association or, to our shame be it said, by the commercial agency which always has believed in the value of advertising.

There must be someone, at all times, authorized to speak for your organization and capable of presenting it in the right light that will engender the proper reaction. And that in turn means a predetermined course of procedure for the organization, built on long range ideas. When I consider the difficulty in selecting an individual or program satisfactory to all the nursing groups of a community, I can quite sympathize with Stephen Leacock's whimsical hero, who took horse and galloped rapidly away in all directions.

Many an opportunity for valuable publicity has been lost because the local press could not get a statement from an authoritative source in time for it to be of use. By the time various committees could meet to pass upon the information requested, it was no longer news.

One of the medical societies in my state has a plan which has been pronounced most satisfactory by the press. One doctor is appointed chairman of the press reference committee for a limited time. He has on his committee, doctors representing the various branches of the medical profession. Whenever a subject of public interest or importance comes up, the papers call the chairman and he, in turn, either answers the questions for them or refers them to the member of his committee most suited to handle the subject. When the press quotes one of these men, it is always as "So-and-so, a member of the Press Reference Committee of the Medical Society." That absolves the doctor of any suspicion of self-seeking, and at the same time adds weight to his authority. Since the personnel of the committee changes yearly, the system should not engender any professional ill-will among the members of the society.

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[1] Read at Registry Round Table, No. 2, Milwaukee, Wis., June 12, 1930. General Session, Administrative Policies and Registry Department.

Such a plan might be followed, with profit, by a nursing organization. It would "put us on the map" in our communities, for some of us are harder to locate than the proverbial needle in a haystack.

If we are publicity-minded, we shall recognise many opportunities for bringing our service to the attention of the public. The present widespread interest in the high cost of being sick, or of getting well (if you have a good nurse) makes it comparatively easy to get space in the papers for nursing subjects.

Last April, the Health Commissioner of my city commented on the unusually low rate of illness in the community which he attributed to the increase in health education. The press gave double column headlines to his story which they rounded out by statements from the medical society, some of the hospitals, and the official registry. Our records showed that the slump in nursing practice was caused by the absence of the usual grippe epidemic which has been appearing regularly every year since the Great War; and a marked increase in the demand for practical nurses indicated that depressed financial conditions had cut into the work of the graduate nurse. This opportunity for publicity was used to bring to the attention of the public, first—the name of the official registry of the local nurses' association; second, the effect of the unusually healthful season upon the income of the private duty nurse; third, the value of part-time or hourly nursing in reducing the cost of illness.

Another instance: There is a weekly bulletin sent out by the Health Department of my city, which reaches doctors, hospitals, and all health organizations. One of its issues, last year, carried an article which discussed Dr. Burgess' book, *Nurses, Patients and Pocketbooks*. It ended with the statement, "We have no quarrel with the nurses for attempting to improve their economic status, but we feel strongly that the greatest problem confronting us is to provide effective bedside care for self-respecting individuals of small means." The following month, this health department bulletin's front page was headlined, "Hourly Nursing Service in Brooklyn," because another opportunity for timely publicity had been utilised by the nurses.

Other methods which demand no outlay of funds are talks to women's clubs and church societies, for today women are the largest purchasers of nursing service; addresses to chambers of commerce, high school assemblies, medical boards, hospital trustees, student and alumnae nurse groups. Radio talks on such subjects as "What To Do When You Need a Nurse" have proved their value. Mimeographed copies of such a talk by Janet Geister can be procured from the Headquarters office of the American Nurses' Association in New York. It goes without saying, that the presence of lay persons on your registry committee also has a definite publicity value, for each one will serve as a focus for information concerning your work.

In planning a publicity program,

the first step should be a survey of the resources for nursing in your community, and its unmet needs; second, an interpretation of these needs to the [illegible] of your association; third, a [illegible] statement to the public and [illegible] of facts regarding the purposes of your organization and the [illegible] you are prepared to offer. It should be written in plain educational [illegible]. Our method of approach should be based upon the questions arising in the mind of a person needing a nurse: "Where can I get a nurse?" "How much will it cost me?" "Who vouches for [illegible] reliability and trustworthiness?" The story we tell the public should produce in the mind of the [illegible] purchaser of nursing service the impulse to call the official registry of the district and should inspire a feeling of confidence.

[illegible] statements in the form of folders or pamphlets are useful thus:

1. [illegible] have been mailed to everyone who [illegible] registry for a nurse.
2. [illegible] have enclosed them with their [illegible] bills.
3. [illegible] been left at other places where [illegible] might ask for information [illegible] nurses, such as hotels, clubs, [illegible] drug stores and clinics.

At slightly higher costs, such publications can be mailed to the doctors through the mailing list of the [illegible] medical society which as a rule is [illegible] to professional nursing organizations for a moderate charge.

[illegible] postcards, sent out in waves every [illegible] weeks, through the same list, have been useful in reminding the [illegible] physician that the nursing profession looks for support to the medical profession in its effort to [illegible] and competent nursing [illegible] the sick.

[illegible] important places for nurse registry advertisements are the local medical journal or bulletin and the classified telephone directory. One registry drove a commercial registry advertisement out of a county medical journal by protesting to the physicians, and taking the space themselves for the official registry. Local publications devoted to the interests of women are also good mediums.

Our publicity should reach out to the nurses in our communities. They are reached through conference with the individual when she applies for membership; through district meetings, alumnae groups and mass meetings for the unorganised nurse. By way of the printed word, we use the district bulletin, our professional journals, and advertisements on the covers of nursing charts. The new registry should circularise all the nurses it can reach in its community.

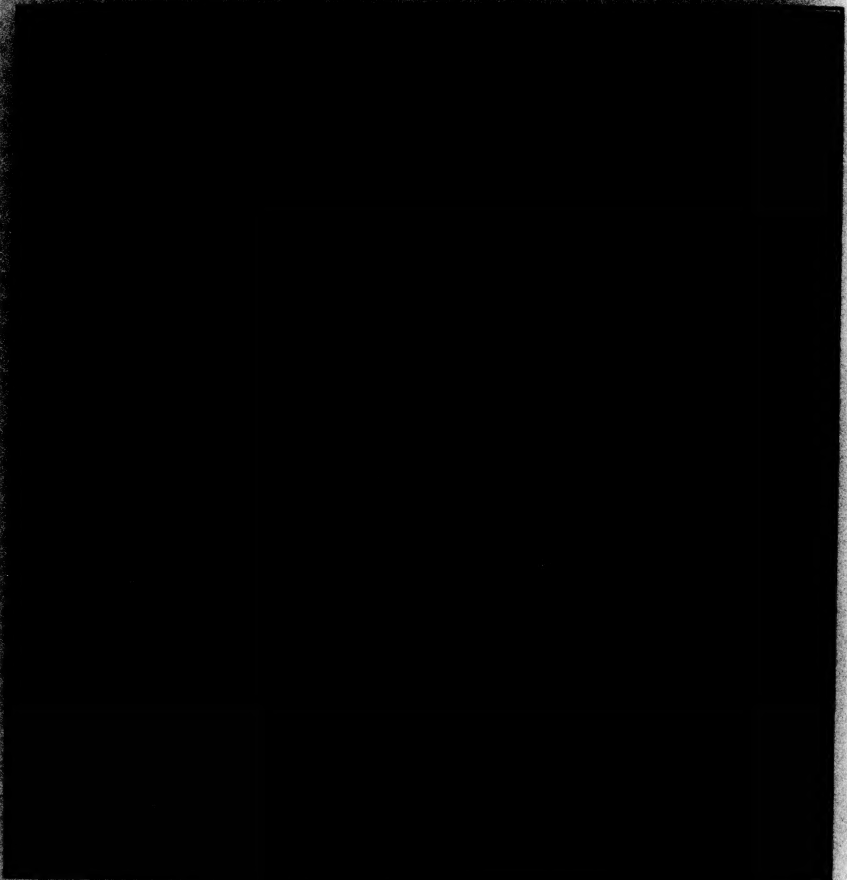
Our principal selling points for nurses are: the self-government of official registries which has an appeal to all intelligent women; the low cost of registry service as each member pays her share of the over head and any surplus is turned back into the general funds of the association for the development of group projects; the maintenance of high standards, for nurses like to be proud of their registry; and many other good features such as lessening the hours "on call," which the individual registry has worked out in varying degrees for the benefit of its members.

The registrant also has her share in the responsibility for education of the public in the meaning of "R.N.," in the need for a shorter working day in the private duty field, and in the use of the part-time service for chronic and convalescing patients.

Good teamwork will produce better publicity than any mere outlay of money, for the most important factor in impressing the public consciousness is keeping our message before it.

Ultraviolet Light and Children's Eyes

MARION R. CHALMERS, R.N.



THE devices used for protecting eyes during ultraviolet treatment were unsatisfactory in that they frightened the children. This canopy solved our problem. After the first few visits to the light room the children seem to enjoy the treatments; they can see what is going on about them, and play with washable toys. The canopy, built of ¾-inch wood, painted black inside and out, is heavy so it is not easily tipped. Two children can be treated at once and do not come in contact. The lamp stands back of the canopy; a projecting arm allows it to extend out over the bed. The canopy, on the far side of the bed, protects the head while the body is exposed to the direct rays of the lamp. An extension board, 12 inches by 24 by ¾, is placed under the mattress far enough to hold it securely.

Cost of Nursing Service in the Hospital[1]

ROBERT E. NEFF

DEEPLY significant today is the subject of this discussion when considered in its relationships to nursing education. It is not ridiculous to prophesy that nursing is due for a rapid and inevitable change in its status before many more years have transpired. The Grading survey, the discussions relating to nursing education which we hear on every hand, and the surveys of the various hospital and medical associations and affiliated groups, tend to accentuate and substantiate this prediction.

The hospital administrator views the present trend in nursing education and its interrelated nursing problems with deep interest and concern, not with any concern of alarm or suspicion, but with one that engages a consuming interest in one of the most important phases of his hospital responsibilities.

Good nursing service is perhaps the best advertisement that a hospital may have; consequently, the efficient nursing care of the patient is an assurance which every hospital administrator constantly seeks.

The needs of nursing service in the hospital, instead of how many students may be properly educated, has been the basis upon which our training schools have been operated. The hospital, by reason of its dependence upon student nurses, has been obliged to arrange the matter in that manner, since the cost of nursing education has been borne by the hospital; the economic factors involved have forced hospitals and training schools to this [illegible] according to custom and tradition we have carried on a joint program of nursing education and patient nursing service, thanks to the leaders in nursing education who, through their studies are pointing a way for better standards in nursing education. This, we are sure, with the help of the hospital authorities, can be accomplished in a reasonable degree and to the mutual satisfaction of all groups. The hospital is interested in nursing education and desires to maintain its place in the field of nursing education. The hospital will be considered less progressive and less safe in which to care for the sick and injured unless it performs an educational service. Its excellence in respect to diagnosis and treatment of disease depends largely upon the extent to which it fulfills the educational function. It seems that hospitals have been satisfied to conduct training schools as long as they were assured that the outlay for the education of the nurse would not exceed the returns in nursing services. It must be admitted that nursing education has failed to receive proper responsibility, perhaps, and obligation on the part of the hospital authorities, but responsibility for the present situation must not be charged entirely against the hospital. The aspect of the hospital administrator toward the nursing problem has naturally involved the economic phases of the subject. Any severe financial burden imposed by the training school naturally strikes a chord, vital in its concern to the hospital administrator. No hospital should exploit the student nurse. The need of the hospital for cheap labor is not a legitimate reason for maintaining a school. Whatever financial returns are gained by the hospital through the services rendered by student nurses should be returned to the benefit of education. On the other hand, the hospital should not be expected to bear the financial burden in educating the nurse with a corresponding obligation on the patient's purse.

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[1] [illegible] of a joint session of the three national [illegible] organizations on "Nursing the [illegible]" at Milwaukee, June 10, 1930.

On the basis of this even balance theory, we shall find it difficult to accomplish our aims in promoting better nursing education, just as we have in the past. To pay for her education with her services, a student has been compelled to spend more time in ward practice than the educational content justified, consequently, another basis must be sought.

Is it not feasible, therefore, to consider nursing education as a separate and distinct problem, and to place the schools of nursing under educational auspices, with hospital affiliations sufficient to provide the required ward practice? Schools of nursing should function on a strictly academic basis, the same as schools for other professional groups. Under this plan ward practice would be limited to the period of time necessary for educational purposes, and the academic requirements would receive paramount consideration with a lesser emphasis on the obligations of the school toward the nursing service needs of the hospital. Nursing education should be regarded as a public responsibility and, further, if society wants good nursing service, it must pay the cost of nursing education just as it does of educating physicians, lawyers, engineers and other professions.

The advancement of educational standards will result in a very marked reduction in the number of schools. The raising of standards with its corresponding increase in the cost of nursing education will tend to reduce the number of student nurses in training schools, just as medical students have been reduced in the past decade during the development of higher standards in medical education. The larger hospitals and the university schools will have to be depended upon chiefly to supply the demand for nurses. Hundreds of smaller schools will be eliminated with a marked reduction in the 20,000 or so graduate nurses now produced each year. All are familiar with the development of medical education during the past decade with its far reaching and significant changes in the types and number of medical schools, as well as the reduction in the number of graduates. May we predict a somewhat similar course in the development of nursing education.

A greater dependence upon the service of graduate nurses is the alternative for the hospital. The adoption of the graduate nursing service plan will naturally, according to economic laws, tend to create a greater demand for graduate nurses with a corresponding reduction of the widespread unemployment of graduate nurses. This fact, together with the reduction predicted in the number of nurses produced, creates no little concern in the mind of the hospital administrator. A shortage of graduate nurses would interfere seriously with the program of graduate nursing service as a substitute for student nursing service. Let us, therefore, consider this factor with careful and deliberate approach to the problem. The laws of supply and demand must be reckoned with and a failure to recognize this situation is sure to bring about financial embarrassment to the hospital.

The first impulse on the part of the hospital administrator is to count the cost. What is the administration of graduate nursing service going to cost the hospital? This factor determines, in a large measure, the extent to which the hospital may go in this plan.

Every hospital administrator should know whether the training school is, or is not paying its way.

The graduate nursing service in many hospitals will impose additional financial burdens upon the hospital operating budget—to what degree is a matter for each hospital to determine. We do not agree with the statement that all hospitals can operate at less cost with graduate nursing service than with student nursing, or even at the same cost. We do predict, however, that many hospitals may fall in line with the advancing standards of nursing education and substitute general duty graduate nursing service for student service, with a comparatively slight additional financial cost, provided the student nurse or her school, through some avenue of financial assistance, is willing to pay that portion of her expenses which her services do not pay for. Fortunate indeed is that hospital which has not been exploiting its training school. That hospital, however, which through exploitation has infiltrated its training school advantages into its financial structure, will find it a difficult financial problem to conduct a school under the impending educational conditions. The exploiting hospital then is the one which will be chiefly concerned from the financial viewpoint. Can it endure the financial strain incident to the maintenance of the training school under the improved standards? If not, then it will find itself in that group of hospitals whose training schools are not likely to survive.

At the University of Iowa, a study has been made of the costs under present conditions, with the conclusion that the school of three hundred students in the hospitals with seven hundred patients, is rendering sufficient nursing service with its students to reimburse the hospital for the financial outlay necessary to conduct the school,—a most pleasing situation from the standpoint of economics. Any appreciable change in the curriculum involving additional costs, or a lesser number of ward practice hours, however, would throw the balance against the school with a corresponding obligation of the school to meet the deficit.

In our contention that the non-exploiting hospital can meet the advancing standards, let us present the following table indicating the comparative cost of conducting a training school where the student by her services pays her way, with a plan whereby the ward practice hours may be reduced to a proper educational standard with a substitution of ward maid service and general duty graduate service. The table illustrates the plan for the three year course on the basis of a forty-nine week year, a six-day week and an eight-hour day.

Present Plan

Freshman Year:	
Hours of nursing service rendered, 1,190.	
Cost to hospital for maintenance and education	$650.00
Cost per hour to hospital	54.6¢
Junior Year:	
Hours of nursing service rendered, 1,898.	
Cost to hospital for maintenance and education	650.00
Cost per hour to hospital	34.2¢
Senior Year:	
Hours of nursing service rendered, 2,368.	
Cost to hospital for maintenance and education	650.00
Cost per hour to hospital	27.4¢

The above indicates a total of 5,456 hours of nursing service rendered at a total cost of $1,950.00 to the hospital which means an average cost of 35.7 cents per hour paid by the hospital for student nursing service.

Alternate Plan

Proposes to substitute ward maid service for freshman service with a consequent elimination of the freshman student from ward practice assignment and further a reduction of 30 per cent in the present number of ward practice hours for junior and senior students with a substitution of graduate nursing service therefor at the rate of 55 cents per hour. The rate for graduate service is based on a cost to the hospital of $85 per month salary, plus $41.70 per month for maintenance, for a forty-eight week year, a six-day week, and an eight-hour day.

Substitute for Present Plan

Freshman year:	
No ward practice	$000.00
1,190 hours' service by ward maids at 25 cents	295.00
Junior year:	
1,329 hours' service by junior students at 30 cents	398.70
569 hours' service by graduate nurse	312.95
Senior year:	
1,658 hours' service by senior students at 45 cents	746.10
710 hours' service by graduate nurse at 55 cents	390.50

Total number of service hours, 5,456 at a cost of $2,143.25 for the three year period, or an average of 39.2 cents per hour. The elimination of freshman ward practice and the thirty per cent reduction in junior and senior practice hours with the consequent total of 2,987 ward practice hours, we believe meets the approximate requirements according to better educational standards proposed at the present time.

A comparison of the cost therefor in the two plans indicates that the hospital may adopt the alternate plan with an additional cost of $193.25 per student nurse per three-year period, or a total additional expense of 10 per cent added to the nursing budget. Under the alternate plan we find that the student nurse with her ward practice reduced to 2,987 hours, earns a total of $1,144.80 on the basis of 30 cents per hour for junior service and 45 cents per hour for senior service. Allowing the student credit for this service against the total of $1,950, which represents the cost of her maintenance and education, we find that she is indebted to the hospital to the extent of $805.20 for the three-year course, or the sum of $268.40 per year. Any additional costs for educational expense purposes would increase the obligation of the student accordingly.

Perhaps it should be emphasized that the cost figures in the foregoing statements are based on the fact that the hospital continues to provide maintenance for students. Most hospitals have considerable investments in nurses' residence property, and naturally desire to continue their use for that purpose.

We are confident that the progressive hospital is willing to assume the additional financial burden incident to the promotion of educational standards, and likewise should the training school or the student nurse accept the added expense imposed by the advancing standards. The hospital will accept the challenge, not in the spirit of financial sacrifice, but with the conviction that it makes a contribution to nursing education and at the same time provides itself with a better type of nursing service.

Group Nursing[1]

SHIRLEY C. TITUS, R.N.

I FEEL the title of my paper is rather misleading. The expression "group nursing" has become immensely popular during the past few years, probably because of its brevity and its newness. Whatever the reasons for its popularity the fact remains that the expression "group nursing" is being used very loosely and very incorrectly. "Group nursing" used correctly and in the strictest sense of the word, applies only to that system of hospital nursing wherein patients are transferred to a special ward unit for the purpose of being "grouped" in such a way that they might receive nursing care from a graduate nurse at a lower cost than is usual for such service. In other words, in these "group nursing" units two patients will share the services, and the expense entailed for the same, of the graduate nurse who is assigned to their care. Unfortunately the expression "group nursing" is being applied to any and every plan of nursing the hospital sick with graduate nurses—the old familiar system, "the special nurse" system, being the only exception.

I really propose to touch on some of the high points in the various new systems of nursing the hospital sick with graduates. I shall discuss "group nursing" but only as a part of the whole subject.

Each year finds a larger number of hospitals employing graduate nurses to render bedside care to the hospital sick. I feel certain that this new departure in the hospital-nursing world is not a temporary arrangement designed to meet a passing need, nor will it long remain sporadic in nature. There are certain reasons that seem strongly to indicate that this movement will prove to be both widespread and permanent. These reasons relate directly to the general trend in hospital economics and hospital administration. I personally believe the hospital world is on the verge of undergoing great and far reaching changes; that it is indeed at the dawn of a new era. This new era in hospital economics and hospital administration will stimulate and promote the growth of these new systems of nursing the hospital sick that are just now becoming known as group nursing and general duty nursing. These two systems, of course, will probably not remain the only systems—new schemes, new plans, and new systems will be worked out as more hospitals are compelled by force of circumstances to give up the old idea that the entire load of the bedside care of the hospital sick shall be carried by student nurses.

What is this new era in hospital economics and administration—what will be its characteristics? The two outstanding characteristics that will mark it out from the hospital world of yesterday will be: (1) the great size of the hospital—it will be an era of big hospitals; (2) hospitals will be administered by individuals thoroughly and highly trained in the technic of modern business and the institution will rest on out-and-out thoroughgoing business methods.

The principal reason why I am led to believe the hospital world of tomorrow will bear these characteristics is because the ever mounting cost of overhead is compelling all hospitals to look to the business world for aid and advice. We are fast leaving behind us the old idea that the hospital is not a business venture because it happens to be a non-profit-earning organization; the hospital of today must be thought of as a business and must run on thorough-going business lines or else it will be forced to close its doors in the not far distant future. I say the hospital must look to the business world for aid and advice if it is to continue its existence. When it looks to the business world what will it find? What are the characteristics of the business world today?

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[1] Read at a joint session of the three national nursing organizations on "Nursing the Community" at Milwaukee, June 10, 1930.

Business Principles in Hospitals

MODERN business, as I see it, rests on three principles, to wit: (1) large scale production (2) very small profit per article (3) the meticulous examination and scrutiny by trained and scientific minds of every operation necessary in the manufacture and selling of the finished product; cost accounting and cost analysis are indeed the wonder of the modern business world, developed in order that this article be produced at the lowest possible cost.

Already hospitals are following in a way the general trend of the business world. They are, for example, becoming very much interested in the reduction of overhead by plant enlargement. What state has not its one or two huge medical centers, centers that find their counterpart in the "merger" of the business world—and is it not true that there is a pronounced movement to build larger and larger hospitals? The small hospital we have with us, and shall have, for some time to come but its future is questionable for they are business anachronisms. Should we not also think of how yearly improvements in rapid transit will affect the little community hospital. Will more and better roads, more and better automobiles, more and better aeroplanes encourage the growth of small hospitals? I hardly think so.

This movement toward the establishment of the very large hospital, or the huge medical center will profoundly affect nursing as I see it. Even if the huge hospital were desirous of nursing its sick solely and exclusively with student nurses, and it is unthinkable that it should, in the light of the findings of *Nurses, Patients, and Pocketbooks*, it does not seem at all probable that the growth of the nursing school can possibly keep pace with hospital bed expansion.

Group nursing, general duty nursing, and other similar systems will be resorted to as the old system of nursing the hospital sick breaks down. It seems most probable that each year will find more and more hospitals compelled to resort to these newer nursing systems. It behooves every nurse, therefore, to think seriously and dispassionately about the problems involved in the new order of things. It is not a matter of whether we like the change or not; it is imminent, I am sure, and if we are wise we shall bring our minds, not our emotions, to a threshing out of the problem.

While the final mechanics of setting up any of these new systems is, of necessity, the task of the director of nursing, nevertheless, I believe the private duty nurse shares with her the responsibility for the success or failure of the new nursing systems. The new nursing systems will affect the private duty nurse very greatly, therefore she, of all nurses, should be thinking over the points of the system that affect her and she should be prepared to render proper advice and assistance relative to the working out of any of these systems at any time. It offers a challenge to the entire private duty group. If the problem is not settled to your liking I think you have no one to blame but yourselves. Do not, therefore, sit by, private duty nurse, and trust that the director of nursing alone can adequately protect your interests without your thoughtful advice or support.

These new systems are not easy to set up. Some of the complex problems involved in the establishment of these systems I shall now discuss briefly. I must say at the outset that before any hospital can possibly set up one of these new systems and attempt to operate it, it is imperative that the problems involved be first worked out carefully on paper. The more care is exercised in working out the problem satisfactorily on paper, the greater the probabilities that the system will prove satisfactory to all concerned.

Define Type of Nursing Desired

THE first step to be taken in establishing any of the newer nursing systems is to secure a clear-cut, definite decision from the board of trustees as to the *kind* or *quality* of nursing service they desire. Do they wish an excellent nursing service, a fair nursing service, or do they wish to thin the nursing service to the greatest possible degree? Let us think in terms of the numerical ratio of nurse to patient at this point. [illegible] we say a Grade A, or excellent, nursing service shall be a service based on a ratio of 1-3 or 4 per twelve hours (that is, one nurse to every three or [illegible] for the 12-hour period); [illegible] Grade B, or fair nursing service [illegible] a service based on a ratio of [illegible] 6, and a Grade C, minimum [illegible] be based on a ratio of 1-6 [illegible]? The board must take in [illegible] the character of the [illegible] its financial status, the kind [illegible] cared for, et cetera, before they can properly make any decision relative to the kind of nursing service they desire and think essential for their hospital.

The next logical step to take, of course, is to ascertain, as accurately as possible, the quality (based on numerical ratio of nurse to patient) of the nursing service in actual operation in the hospital at the time of discussion. One warning must be raised at this point. It must be clearly understood that in estimating the ratio of nurse to patient, it is not sound to take the gross number of nurses on duty in the hospital and compare it with the total number of patients in the hospital. In an estimate of this sort all nurses assigned to such services as the operating room, surgical supply room, diet kitchens, et cetera, must be excluded, only the number of nurses *actually assigned to the bedside care of patients* should be included in the count. It is interesting to note that the average board of directors and hospital director can tell you to a T how many nurses are on duty in the hospital, but there are conspicuously few who have the faintest notion of how many of these nurses are actually nursing patients!

After the board has decided the kind of nursing service needed for the hospital, and having received the statement of the actual numerical ratio of nurse to patient in their institution at the time of discussion, they can then approach the question of how many graduates it will be necessary for the hospital to employ in order to supplement their present nursing service to the point where the desired service—desired ratio of nurse to patient—is possible.

This question immediately and automatically raises another question—what system shall they use, group nursing or general duty? The group nursing system requires about twice as many nurses as does the general duty system (the distribution is usually 1–2 for group nursing, and 1–4, or more, for general duty). The group nursing system differs widely from the general duty system. We will now consider for a moment a few of the differences between the two systems.

Group Nursing or General Duty

FIRST, there is a difference in objective. Group nursing is designed primarily, if not exclusively, for the purpose of reducing the price of "specialing"; it does not improve or enrich the general nursing service of the general ward units. The objective of the general duty system is the enriching or improving of the general nursing care of all the patients in the hospital by establishing a better numerical ratio of nurse to patient. In other words, in considering these two systems, the board of trustees must decide whether they wish to encourage "specialing" by bringing about a reduction in this "special" service, or whether they are more anxious to improve the general nursing care throughout the hospital. The fact that a good general nursing service distinctly curbs and discourages the employment of "special nurses" must not be lost sight of. Many patients employ special nurses not because they, the patients, are extremely ill or because they are desirous of securing "luxury service" but because it often happens that floor service is so miserably poor the patients in nervous desperation employ a special nurse whom they can, perhaps, ill afford.

Group nursing presents a difficult architectural and admitting-department problem, but little or no financial problem for the hospital to solve; general duty, on the other hand, presents no architectural and no admitting-room problem but does present a complex financial problem for the hospital to solve.

The general duty nurse can be assigned to duty in any ward unit in the hospital; she can be substituted for the student nurse or she may work side by side with the student nurse in any unit. The general duty system, therefore, is a very flexible system for the nurse can be transferred easily and quickly to and from any ward unit as the hospital exigency demands.

The "group" nurse can be used only in a limited way. She can be assigned only to the one or two units where the patients are grouped to receive this particular and special kind of service; she can not be moved to other units regardless of the shortage of nurses. The "group" nurse is, in fact, a "special nurse" who is doing "divisional specialing"—that is to say, she is a special nurse whose services are being divided between two patients. Her rate of pay is lower merely because she is employed by the hospital on a monthly basis and is given steady, uninterrupted employment. Because of steady, daily employment she can afford to sell her services at a lower rate per day than would be possible if she bore alone the financial loss which always faces the worker engaged in a seasonal occupation.

Group nursing can not be used in every hospital, for it requires a special architectural lay-out; namely, a private corridor with connecting rooms. Any hospital can adopt the general duty nurse system as this system does not require a special architectural lay-out.

Group nursing presents a very difficult problem from the viewpoint of the admitting department for the group nursing unit must be kept full always unless the hospital is to suffer a severe financial loss. This necessitates much extra-ward transferring. It also necessitates constant and eternal vigilance on the part of the officers and staff of the hospital and great coöperation from the staff of attending men.

Group nursing presents no financial problem to the hospital for the entire cost of the service can be charged back directly to the patients enjoying that service. In other words, the hospital handles the financing of group nursing as it does the special nursing costs—as a direct, "extra charge" item.

As the general duty nurse takes the place of a student nurse, so to speak, the hospital, as a rule, does not feel it can make an "extra charge" item for nursing service rendered by this group. It has, of course, been customary that the room rate normally was fixed to include standard hospital service which every patient requires such as room, board, laundry, nursing service. The fact that the hospital takes this attitude discourages the introduction of general duty nursing for the hospital sees in such a system another expense added to its overloaded budget. No doubt this is why group nursing, as such, finds greater favor from the viewpoint of the hospital administration than does general duty. As I see the problem, it is a question of how much nursing service can or should be offered by the hospital under its present system of expecting the room revenue to cover general nursing (good or bad as it may be). Should we attempt to furnish Grade A or Grade B nursing service for the general run of patients in the hospital? Should we continue to encourage "special nursing" and its [illegible] [illegible] sister, "group nursing," and be content with this floor service? Would it not be better, perhaps, to offer a good floor service, even though at an increased cost to the hospital? Would it not be possible to distribute this extra cost over all the patients by, perhaps, adding a nominal daily charge for nursing service?

This whole question is a burning one and deserves serious thought on the part of every person who comes in touch with the problem. It is, of course, obvious that we shall never really be able to grapple with the problem properly until the hospital has installed a fine cost-accounting system and there has been a proper cost analysis made on departments and schools of nursing. However, I have thrown out some questions in order that the magnitude of the question may be understood. With the old system of student nurse service breaking down, how shall we meet the situation? What is best for the patient? And how shall we finance these new systems of nursing?

The length of this paper forbids my speaking except in a very brief and passing way on two other important problems relating to these new nursing systems; namely: (1) terms of employment; and (2) "taking up the slack" when the hospital census drops.

The two points I wish to make in relation to terms of employment of the graduate nurse for either general duty or group nursing are: hours of duty and salary can not be settled arbitrarily by the hospital authorities neither can they be settled on the basis of what some other hospital, perhaps in a different city, is offering for such services. The hours of duty and salary for these nurses can be settled only on the basis of what hours and salary the private duty nurse in the local community is enjoying. To make these new nursing systems possible and popular, they must be made as attractive and desirable as private duty. When the hospital sets up the new system it is having to bid against an old, familiar, and therefore popular system (for the known is always the loved, the new is the feared). There is a bit of psychology involved here that cannot be ignored.

I feel before I leave this point of "terms of employment" I must throw out one warning. The institution is short-sighted indeed which attempts to set up general duty or group nursing on a basis that every time the hospital is busy the system can be set up and when its census is low the system can be abandoned. General duty and group nursing rates should be set for permanent, uninterrupted service—it is this regular employment of the nurse that permits her to give her services at a lower daily rate than that earned by the private duty nurse. Unless this idea is firmly grasped, the nurse doing general duty or group nursing will be exploited and the whole system will become intensely unpopular in a short time.

How are we going to protect ourselves from financial loss, then, when the census drops and we have either of these newer nursing systems in operation, you ask? There are two ways only, as I see it: Some "slack" may be "taken up" by using general duty nurses or group nurses for "specialing" (and of course, permitting them to receive the regular rate of pay of the special nurse while doing so). However, the main protection the hospital has is gained through a very painstaking analysis of the [illegible] daily and monthly occupancy of the hospital over a period of several years. Slack periods and high census periods do not come as erratically as would appear without study of the question. With usual monthly turnover in the group nursing or general duty nursing staff, plus the fairly reliable figures one can secure on expected monthly occupancy, the size of the nursing staffs can be fairly well controlled in relation to the number of patients to be nursed. This problem requires careful thought and study as, however, do all the problems relating to these newer nursing systems.

Drug Addiction

During the past three years there were 11,[illegible] persons committed from the Continental United States to Federal Institutions for violation of the Federal Narcotic Laws, or an approximate annual admission rate of [illegible] persons. Of this number [illegible] per cent were women. More than three-fourths of each sex, as committed, were addicted to the use of drugs. Approximately [illegible] per cent of those released from such institutions, after serving sentences, were recommitted for subsequent violations of the Narcotic Laws.—Walter L. Treadway, "Drug Addiction; Some Epidemiological Features and Individual Characteristics."

Most Nurses Have High Educational Standards

Examinations given to candidates for enrollment as registered nurse during the past two years show clearly the development of a higher standard in nursing throughout the country. [illegible]

Coördination of Nursing Resources in a Community[1]

M. JOSEPHINE SMITH

THE Central Committee on Nursing in Cleveland was born in April, 1914, although for the first five years of its life it was known as the Central Committee on Public Health Nursing and its membership and activities were confined to the public health nursing groups. However, when Dr. Haven Emerson made his Cleveland Hospital and Health Survey he expressed the belief that the activities of the Committee should be extended; and the way was opened to do this when, in 1923, the Red Cross asked the Committee to take over the task of supplying students for the schools of nursing of the city. In response to this request the Central Committee took over the Red Cross Student Nurse Recruiting Committee, which consisted of the directors of all the accredited schools of nursing in the city, together with certain lay people especially connected with, and interested in the problems of nursing education; and it became a Sub-Committee on Nursing Education, its executive secretary, Frances B. Latimer, retaining her position in charge of this particular part of the Central Committee's work. Thus, in 1924, the Central Committee entered the field of institutional nursing and its services to the community became, from that time on, of a much broader character. In the sketch of what those services have been, which I will now try to give, it must be borne in mind that this organization has been an accepted part of the public health nursing organizations of Cleveland for sixteen years; whereas its share in the institutional organization of the city began only six years ago; therefore the results achieved in the former field are much more complete and the work is much better organized than in the latter, although there also considerable results have been gained.

The Central Committee has had in mind, from the beginning, certain clear and important objects; these may be broadly outlined as follows:

1. To coördinate, as far as possible, the various nursing organizations of the city.
2. To maintain equal standards of high professional training as a requirement of all the organizations represented.
3. To provide a meeting ground for the discussion of matters affecting nursing service, from the point of view of the public served, as well as that of the nurse giving the service.
4. To promote efficiency and economy in the provision of personnel to staff the various organizations; and to make the experience of one group available for the use and benefit of all.

I will now try to show how the Committee has attempted to achieve these aims and in how far it has been successful.

To Coördinate All Nursing Organizations

So far as the public health nursing organizations are concerned, there is probably no part of the Central Committee's aspirations which has been more successfully achieved than that of coördination. It is not boastful, I think, to say that Cleveland is known for the coöperative spirit of its public health nursing groups; how far this is due to the very friendly and close relationship which has existed for so many years between the superintendents of the various staffs in their constant meeting as members of the Central Committee, or how far the possibility of these friendly relations in the Committee is due to the coöperative spirit abroad in Cleveland, someone else must decide. One thing is beyond dispute, however, and that is that no meetings could be more frank in discussion or more cordial in spirit than those of the public health nursing committee; and it would be difficult to say how many possible causes of contention have been removed almost before they were perceived, through the informal conversations between individuals, as well as the group discussions at those meetings. In looking back, it is most interesting to trace the growth of some fine, sturdy plant in the public health field, to a tiny seed dropped by a member at one of these discussions.

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[1] Read at a joint session of the three national nursing organizations on "Nursing the Community" at Milwaukee, June 10, 1930.

The membership of this group is very complete, for it includes representatives from all the public health nursing organizations of the city—the Health Division, the Board of Education, the Visiting Nurse Association, the University Public Health Nursing Station, the Dispensaries of Maternity Hospital and the Babies' and Children's Hospital, and the Red Cross Teaching Center. The representatives are, in each case, the director of nursing service and a board member appointed annually by the member organization; in the case of the City Health Division, the Commissioner of Health is a permanent member, and so is also the Medical Chief of the School Health Service.

In the hospital field the membership is also complete, if we exclude the private hospitals. The nursing superintendents of fourteen hospitals sit on the Committee, and all the accredited schools of nursing are represented by their directors.

It will readily be seen that with such a membership the deliberations of the Committee are fully representative of the needs and views of all groups, and any recommendations made carry great weight.

The quarterly meetings of the Central Committee as a whole provide an open forum for the discussion of any matters affecting all or several groups—such as health of staffs, salaries, uniforms, hours of duty, etc. Whenever necessary because of the subject to be discussed, persons outside the membership can be called in and they may be made members of special committees.

To *Maintain Standards*

Through all the difficult early years of public health nursing, through the hard times of the War, right up to the present day when high standards of nursing are a sine qua non, the Central Committee in Cleveland has maintained one professional standard of admission to all the public health nursing staffs; and any nurse accepted by the Eligibility Committee is, by that fact, professionally eligible to any one of the staffs. In the same way, nurses accepted for institutional work must have the same professional standard of training, no matter for what hospital they are making application. It is interesting to note that there has never at any time been disagreement as to the standard to be required; nor has any effort ever been made on the part of any staff to fall below the standard set by the Central Committee.

Of course, there are some variations as to what the superintendent of a particular staff desires in the background and experience of her nurses, and from that angle every appointment is an individual one, just as any nurse has the privilege of making application for one particular staff.

The Director of the Western Reserve University Course for Public Health Nurses, or her Associate, attends the meetings of the Eligibility Committee, and because of her contact with students who spend two months of their senior year's training in the University district, as well as with the postgraduate students, her assistance is invaluable. More and more, as the local supply of nurses has increased, the Public Health Committee has given preference to graduates of Cleveland schools who have passed through the University district. There is at all times the closest coöperation between the Public Health Committee and the University district.

And here also the Committee on Nursing Education comes in, for it has steadily and definitely worked to make standards of nursing education familiar in the community, by maintaining a bureau of information to which all young women interested in becoming graduate nurses may turn for help; by talks given in colleges, high schools, and to various groups of young women and their parents and guardians. It has also worked to bring all the accredited schools of nursing in the city to the point of accepting as students only full high school graduates; and I am glad to say that this goal has now been reached and no accredited school in Cleveland will accept anything less.

A Forum for Discussion

The Central Committee, because [illegible]bership includes lay people as [illegible], provides a meeting [illegible] for the discussion of [illegible] nursing service, from [illegible] of view of those served as [illegible] those who give the service. [illegible] day we are hardly [illegible] forget the fact that, while the problem of providing efficient nursing service in sufficient amount to care for our sick is being considered and solved as never before, the equally important problem of providing this service at a cost which the patient can afford has not been met in an equal degree—rather, because of the increased cost of the more efficient service, the public is in danger of being in the position of the proverbial traveller who, though surrounded by water, is unable to quench his thirst; while the nurse, prepared at heavy cost of time and money to give him relief, faces the equally painful position of remaining unemployed.

I cannot, alas! lay claim that the Central Committee has taken any serious step towards the solution of this problem, which is vexing the souls of nursing leaders; however, because of its relationship with all the nursing groups of the city, and because also its membership includes lay people—which means the public—the Committee has been called upon to give some thought to this question, and it is the logical group to give it still more serious thought in the future.

Some while ago there was in Cleveland a strong feeling amongst the private duty nurses that the fees charged for their services were incommensurate with the long hours of professional service demanded in return; while, at the same time, it seemed clear that the public could not meet an increase. Although the Central Committee has never entered the field of private or "special" duty nursing, which is taken care of, of course, by the Official Registry, the matter was referred to the Committee for study, and a special committee was appointed in 1924 which included a number of outside representative people, such as the superintendents—

as distinct from the superintendents of nursing—of one or two large hospitals with important private service, the president of the Academy of Medicine and other leading physicians, as well as influential lay people.

The matter was considered from two angles:

(a) Private nursing in the hospital.
(b) Private nursing in the home.

(a) After long and careful deliberation, three hospitals—Lakeside, Mt. Sinai and Huron Road—were asked to make a "six months" experiment of a ten-hour day instead of a twelve-hour day for "special" nurses, the idea being that these nurses might be allowed to report one hour later in the morning and to leave one hour earlier in the evening, these two hours being cared for by the general floor service of the hospital. It was fully understood that such a change would have to be made only subject to the condition of the individual patient, and that whenever the condition of a patient required it, the nurse would remain on twelve-hour service.

The report from the three hospitals at the end of six months was favorable, but the experiment was continued to the end of a year. When the year expired it was found that nearly all the hospitals in the city were following the plan, and only one, after trying it, had turned it down as undesirable. The experiment was very carefully followed for its results upon the patient, the doctor and the nurse, and it was found that the change brought hardly any criticism from either doctors or patients, while the nurses were much happier and more contented with conditions. One gratifying thing was the constant evidence reported that the nurses never wished to go on ten-hour duty unless the condition of the patient fully justified it. One hospital made it a standing rule at the beginning of the experiment that nurses should remain on twelve-hour duty for three days after an operation; other hospitals, where this rule had not been formally laid down, reported a similar procedure in effect as a matter of course. Needless to say, the control of this always remains with the nursing office, and a nurse is always required to report to the office and obtain permission before going on ten-hour duty.

What was accomplished, in other words, was a reasonable shortening of the nurse's day whenever possible without risk to the patient.

(b) The question of long hours on private duty in the home did not present a very serious problem, since in Cleveland, at least, a large proportion of private duty nursing is done in hospitals, and also, when the patient is cared for in the home, it is usually found that the family are very reasonable about hours and about allowing the nurse time off duty. Here, however, the difficulty mainly centered round the cost of nursing service.

The deliberations of the Committee led it to the conclusion that the most practicable way of reducing the cost of nursing service was through an extension of hourly nursing service; that, in short, it should be possible to obtain the part-time services of a nurse where the whole time is too expensive and, in many cases, is not a necessity for the patient. There are [illegible] nurses on private duty in Cleveland [illegible] and [illegible] of [illegible] fully equipped with a well supervised staff to add to its activities what is known as an "appointment service"—that is to say, a service through which a nurse can be sent to a home at the hour desired by the family. On the request of the special study committee the Visiting Nurse Association undertook a year's experiment along these lines, and through the coöperation of the Cleveland Health Council, a very careful statistical study and report were made at the end of the period. The most significant point brought out by the experiment was that, while the demand for the "appointment service" was not very great, there was a considerable increase in the demand for the regular hourly service, which is, of course, much less costly to provide. The service has been continued as a regular part of the Visiting Nursing program, since the demand for it, though small, showed a need and the possibility of further development.

To Promote Efficiency and Economy

It is not difficult to demonstrate that time and money are saved if one central agency is doing a piece of work, instead of a number of isolated agencies. The placement bureau of the Central Committee completes and files applications for the public health field and hospitals, and openings are filled from these lists as they occur. Some of the hospitals prefer to advertise for nurses under their own names and then to refer the replies to the Central Committee for clearing. It is instructive to note how often the same nurse answers two or three of these advertisements, and [illegible] one of the places where time and energy can be saved. Again, [illegible] applies to Lakeside, say, and [illegible] there is no opening there but [illegible] can be placed in Mt. Sinai; thus the nurse obtains a position and the hospital a nurse, while the hospital without a vacancy need not reply.

As stated before, the Official Registry takes care of all private duty nursing, whether in home or hospital, referring to the Central Committee inquiries and applications for public health and institutional nursing. Applications and references can always be exchanged between the two, and in this way duplication of work is again reduced.

The Central Committee is a member of the Welfare Federation and is financed through the Community Fund, which is in itself, I think, a sufficient criterion that its work is recognized by the community as important public service and also as a measure of economic efficiency. Its services are free to all organizations and to all nurses who use it; and the more it is used, the more the economy gained.

Of course Cleveland has one outstanding advantage in its Nursing Center, which houses a number of nursing groups and, through its club house facilities, gives hospitality to, and constantly brings together all the others; it is, in short, a local 370 Seventh Avenue, and the Central Committee, the Visiting Nurse Association, the Official Registry and the District Headquarters all occupy the very attractive second floor of the Center and can communicate with each other in a few seconds.

In looking back over the years it seems fair to say that the Central Committee has in considerable measure achieved the objects which it set out to attain; but there are always new peaks to be scaled, and the ardent mountaineer never feels that he has reached the end of his ambitions—there is always an Everest still to be conquered.

This, in very general and prosaic words, is the outline of how the Central Committee on Nursing has attempted to serve and promote the cause of community nursing in Cleveland; but I think if you were to ask its oldest members—those who have grown up into and with it—they would say that its most valuable contribution has been, not the accomplishments which can be demonstrated on paper, but rather, the intangible "esprit" which it has helped to create, and through and because of which, many practical benefits follow as a matter of course. If, because of this "esprit," on the one hand Cleveland nursing groups have been drawn closer together and into finer mutual understanding; and, on the other hand, some of those in our great city, poor and rich alike, who are suffering and needy, are receiving better and more economical care because there is a group of people interested in procuring for them the best kind of nursing that our present knowledge can provide, then the work of the Central Committee on Nursing has not been wasted.

Unemployment in New Jersey

New Jersey Hospital Association Coöperates with Nurses

At its annual meeting in Atlantic City, the New Jersey Hospital Association unanimously accepted a resolution, presented by R. N. Brough, Superintendent of the Homeopathic Hospital of Essex County, which should have a far reaching effect on the morale and the conditions of employment of nurses in that state. By upholding the standards of the State Board and of the State Association, the Hospital Association has made a signal contribution to the effort of New Jersey nurses to raise the standards of nursing care in the state. The *Journal* does not, ordinarily, publish resolutions. This one is of such importance that we gladly give space to its exact form and wording.

During recent months there has tended to be a crowded condition in the nursing field within our state, with the result that some of the registered nurses within our borders have experienced difficulty in earning a reasonable income; and certain graduate nurses are practising their profession within the state who have come here from foreign countries, and have failed to register in the state or become members of any recognized nursing organization or association;

Resolved: That the New Jersey Hospital Association requests its member hospitals to give preference, when employing nurses, to, first, graduate nurses registered in the State of New Jersey, and, second, to nurses registered in other states of the Union and eligible for registration in New Jersey; and that this Association further requests its member hospitals to admit as special nurses, caring for private patients within the hospital, only such nurses as are similarly registered, except in emergent or distinctly unusual circumstances.

The Distribution of Nursing Service[1]

MAY AYRES BURGESS

A YOUNG profession, where standards are changing and rising, usually begins to show three signs of professional growth. The first sign is the desire to discover the truth about itself. Of the three signs of progress, this is perhaps the first and easiest. It is easy because in advance of a study one cannot predict the outcome, and, therefore, it needs only a little courage to embark on the self-survey process. It is also easy because a profession, to discover the truth about itself, need not do all of the work alone. It is always possible to hire a statistician.

The Program Committee has asked me to talk about the distribution of nursing service. We know that there is an uneven distribution in the nursing profession. Nurses are crowded into the cities far in excess of the needs of the population. Nurses are hard to find in the country and there are many parts of the United States where large areas are completely unreached by graduate nurses.

Nurses are eager for private duty in hospitals and they are reluctant to fill calls for private duty service in the home. There are too many nurses waiting for calls on week days and often too few ready to work over the holidays. There are many nurses trained and interested in taking surgical cases and there are very few trained and eager to take special types of medical cases. There are thousands of unemployed nurses eagerly seeking for opportunities to become self-supporting, and there are hundreds of unfilled positions which remain unfilled either because nurses are afraid or unwilling to undertake the work, or because there are not enough nurses with the specialized administrative or educational preparation for which some of the unfilled positions call.

It would seem a feasible and a desirable thing for state boards of nurse examiners, the secretaries of state associations, the heads of local registries, and the officers of district and state nurses' associations to work together in a systematic attempt to gather current information concerning the nursing needs and the nursing supply of their community. The state board and the state nurses' association, working together, might well investigate conditions in the undernursed counties. They might perhaps get in touch with the physicians and hospitals in those counties to discover whether, if nurses were to move there, there would be enough work forthcoming to keep them busy. One can imagine these various state and district agencies getting together at monthly intervals in order to exchange information as to the problem of nursing distribution and to act as a clearing house, so that all nurses throughout the state, or other nurses interested in moving into the state, might readily know what the opportunities are for employment.

Courage To Face Facts

THE second sign of progress in a profession, courage—intellectual honesty to face the facts squarely—is by far the more difficult and painful.

Straightforward analysis of the facts of nursing distribution leads one inevitably into dangerous channels. There are many county districts where there is a shortage of nurses; but it is increasingly true that in small as well as in large cities there is so great an over-production of nurses that the registries cannot possibly keep all of them employed.

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[1] [illegible] June 18, [illegible]

Each district needs to ask: Is there unemployment among our private duty nurses? Have we more graduate nurses than our population really needs? Is our supply of new graduates, going into private duty, growing more rapidly than our supply of sick-a-bed patients? If the answers to these questions are all "yes," obviously the district association needs to do something about it.

Reduce the Supply

WHAT can the district do? First of all, it can concentrate its attention on the source of supply—the local training schools. If there are too many nurses coming into the profession there is only one way to reduce the number, and that is to reduce the number of students admitted to the schools.

Over-production of graduates cannot be laid at the doors of the small schools. It is the large schools, not the small ones, which are directly responsible for unemployment in private duty nursing. If over-production is to be stopped, the big schools must stop enlarging their schools.

It is the task of the district association to bring these facts home to its members, and to the community, so emphatically that they cannot be ignored. Every superintendent of nurses whose enrollment this fall is larger than it was last fall should feel the pressure of professional opinion upon her so strongly that she will feel called upon to justify her action to the other members of her district association. She is not merely an official in a hospital, she is a member of a profession. And if by increasing the size of her school she is contributing towards unemployment in her profession, she is obviously under moral obligation to explain why.

If the superintendent of nurses has favored the enlargement of her school she faces a more difficult task in justifying her action to the profession. In a city where graduate nurses are unemployed, the superintendent of nurses who is continually enlarging her school on the plea that the "patients must be nursed" is encouraging the exploitation of nurses for the financial advantage of the hospital. Patients must be nursed, but if graduate nurses are available they should be called upon to do the nursing. Hospitals cannot be blamed for exploiting students when they are encouraged to do so by their own superintendents of nurses. Even when the quality of training is reasonably good, to encourage young women to prepare for a profession in which after they enter they will not be able to earn their daily bread, is exploitation.

There are probably only two conditions which justify the superintendent of nurses in increasing the number of her students. The first is where she can show that more graduate nurses, of the type the school produces, are really needed in the community, and cannot readily be secured from other sources. The second is where she can show that the preparation given in her school is not only better than, but different from, that given by most of the [illegible] schools from which the great bulk of graduates come.

Almost every one of the large schools believes that it is better than [illegible]. It believes that it is justified [illegible] in enlarging its school [illegible] for the new [illegible] because its graduates are "so [illegible]." Usually it is wrong. The small and [illegible] of graduate nurses today have [illegible] from the many small schools [illegible] the comparatively few large schools. Very few indeed of the large schools give the type of preparation which puts their graduates very far ahead of the rest. Most of them could reduce their annual production of graduates with benefit to the profession.

There are a few schools however which give their students something different. If a school has an opportunity to teach the nursing care of mental or nervous patients—really teach it so that its graduates can handle such cases skillfully and intelligently—it ought to admit as many students as its clinical material warrants. Other special services, rarely given adequate attention in the general hospitals, yet representing experience which is needed by graduate nurses, may justify a school in enlarging its student body.

Yet even in these special types of schools it is by no means certain that enlarging the school should mean increasing the number of undergraduate students. With thousands of graduates [illegible] unable to find work, it may be [illegible] of the forward steps for the profession is the development of post-graduate courses in those nursing specialties where the demand is still greater than the qualified supply.

[illegible] the schools alone which, [illegible] are gathered, are under the [illegible] of facing them. Take the [illegible] of the registry for example.

[illegible]—and Private Duty

I[illegible] is concerned as to the [illegible], obviously it cannot [illegible] member who [illegible] fill every call in [illegible] the head of the waiting [illegible] interested in the patient, [illegible] investigate the character and qualifications of every nurse whom it is willing to recommend; and in filling calls it must make a conscientious effort not merely to get the nurse a case, but to get for the patient the kind of nurse he needs.

Most official registries set a flat fee which every nurse must charge. This implies that every nurse is exactly as good as, and no better than, every other nurse on the registry. If one nurse is twice as valuable as another, is the registry quite honest in its dealings when it tells the patients that each nurse is worth exactly $6 a day? If the nurse is worth more, the patient is getting more than he pays for. If the nurse is worth less, the patient is paying for something he does not receive. Is this set fee for all nurses regardless of their quality really ethical?

Is the registry being fair to the patient when it insists that every nurse shall charge $6 a day regardless of the length of the case? Yet there have actually been instances where nurses have been warned that they would be put off the registry if they reduced their charges for long time cases.

New Fields—a District Problem

IT is the registry which sees most clearly the problems of distribution and employment; but the responsibility for remedying them does not rest only on the registry, it rests on the whole profession. It is the task, not only of the registry but of the district, to analyze the local needs for nurses, and to search for methods by which graduate nurses may be helped to withdraw from the overcrowded field of private duty, and to enter other types of nursing for which there is real demand.

One of the most encouraging developments in the past two years has been the number of hospitals which have undertaken constructive experiments for the express purpose of dignifying the position of the graduate floor-duty nurse. Reports come from all parts of the country, from small and large hospitals alike, telling of the increased employment of graduate nurses, the care taken in making the appointments, the careful adjustment of responsibilities so that students will have increasing respect for the superior abilities of the graduate floor nurses, and the resulting improvement in the quality of nursing service which these hospitals are able to provide for their patients. It is in this field that during the past two years the greatest progress has been visible. Other fields are receiving constructive attention. Hourly nursing is being tried in many places, and with varying degrees of success. Plans are being discussed for "refresher" or supplementary courses in order that otherwise competent nurses may be brought up to date in new technics, and so equipped to undertake work where there are unfilled calls. Nurses who are unable to handle the more serious types of illness and yet are eager to help with chronic or convalescent cases where a resident nurse is sometimes needed for weeks at a time, are being encouraged to undertake such cases, not at a daily rate but at a moderate weekly salary sufficient to provide them with a comfortable living and yet within the means of the ordinary family. To make nurses realize that such engagements are dignified, important, and ethically sound, is again a task for the whole district membership.

Energy To Act

THE third sign of progress in a profession is the energy to act after the facts have been known and admitted. Discovering facts is easy. Admitting them is hard. Acting on them takes the middle ground. Action cannot come until the profession has made good progress in gathering and facing the facts, and for that reason there is perhaps less to see under this third count than under either of the other two. Every one seems to be waiting for some one else to tell what to do.

The answer probably will not come from any single group. Little by little from all sources details of planning and action will grow. District, state, and national individuals are talking and thinking. The field is being prepared for courageous action. Specialists are being called in from other fields to help.

Utilizing Specialists

THE beginning of utilizing the outside professions has been made, but it seems increasingly clear that if nursing wants to solve its many problems with the greatest rapidity, it needs to call upon outside professions to a far greater extent than has as yet been done.

The biggest problem for the profession has to do with the training schools for student nurses. It is primarily an educational problem. The fact that women are skillful nurses and skillful hospital administrators does not transform them into educators. Education within the past thirty years has become one of the great professions. Its methods have been refined and analyzed until they are rapidly approaching a science. Literally thousands of technical books on the science of education have been produced within the past thirty years, setting forth facts and philosophy and technics, a large part of which will be found to be directly applicable to nursing education. Professional educators could be of help to schools of nursing in solving their organization problems, their problems of curriculum, courses of study, and of teaching methods. The content and technique of textbook presentation, the administration of psychological tests and achievement tests, budget-planning and financing, record-keeping, public information, the writing of annual reports, the relation of the faculty and executive body to policy-making boards, the relation of the school to the public, all of these and many more are problems to which professional educators have devoted years of study.

The League of Nursing Education has long been recommending that professional educators be added to the training school committee. It would seem equally necessary to add them to the boards of trustees of hospitals conducting training schools. Eventually nursing will develop its own body of professionally trained educators. In the interim there is great need for schools of nursing to call upon members of the educational profession to help them solve the more pressing of their immediate problems.

A similar situation is true in connection with other nursing questions. Nursing has already called upon economists and actuaries for help in solving some of its problems concerning annuities and insurance. It has called upon social service workers for help in [illegible] its relief fund. It has from time to time sought the aid of [illegible], public information workers, and certified accountants to help with other specific problems. It is beginning to call upon personnel workers and heads of great professional employment bureaus for advice as to handling its registries. It is seeking closer touch with the professional and business women's clubs, with newspaper women and magazine writers. More and more this sane solution is being adopted of calling in specialists from other fields rather than continuing to struggle blindly as amateurs, with technics which nurses cannot be expected at the present time to handle correctly. Nurses are rapidly learning to make other professions work for them.

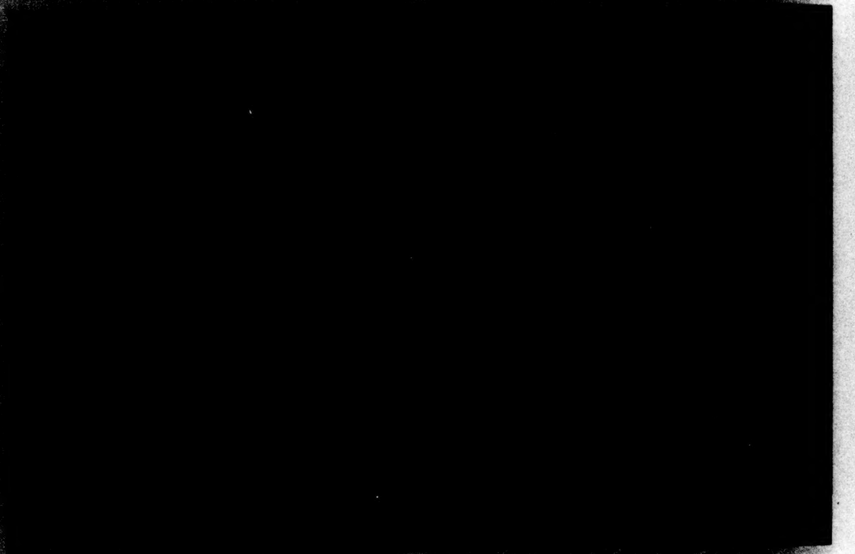
Four Years of Progress

FOUR years, when they are over, seem a very short time, but even so they are long enough for us to see what is beginning to happen. Nursing is beginning to awaken to the fact that it is only one of the many professions, and that the problems which it faces are, for the most part, exactly the same problems which all other professions have faced. In each case there is some peculiar twist or quirk which gives a different aspect, but there is very little in any profession which is genuinely unique.

The work of the Grading Committee is almost over. When the end comes, those of us who have been privileged to join with you in this undertaking will be able to look back, and trace through the five years of our participation, the evidences of steady progress in a great profession which is determined to find the truth, face it squarely, and do something about it.

Hand Cultures from a Student Nurse

[illegible], R.N.



THE above series of plates were made after culturing the hands of a student nurse as follows:

Plate 1—Before beginning care of patient (pneumonia).

Plate 2—Upon completing care of patient.

Plate 3—After washing hands one-half minute. (Soap, running water, no brush. Flow of soap and water controlled by knee and foot.)

Plate 4—After scrubbing hands one-half minute.

Plate 5—After scrubbing an additional minute.

Hands of student were dried on sterile towels after washing and scrubbing, and before culturing.

Cultures were made by immersing hands in basins containing 125 cc. of sterile water and plating 1 cc. of this amount.

"Between Two Years and Six"

"BETWEEN TWO YEARS AND SIX" is the title of a new booklet on the hygiene of the preschool child written by Dr. Richard M. Smith, assistant professor of Child Hygiene at Harvard Medical School. [illegible] child's [illegible] neglected [illegible] valuable [illegible] six years [illegible] with- [illegible] Conservation Bureau of the John Hancock Mutual Life Insurance Company of Boston, Mass.

The Nurse Anesthetist[1]

AGATHA C. HODGINS, R.N.

[illegible] been said that the desire to [illegible] pain is as old as man, [illegible] its fulfilment had long to [illegible]. The discovery of the use of [illegible] therefore followed a long [illegible] of seeking and was, as Sir [illegible] expressed it, the "great- [illegible] gift ever made to suffering [illegible]." This statement en- [illegible] value of a great discovery, [illegible] of which has caused [illegible] of suffering during [illegible] for alleviation and cure of [illegible] hamper and torture the [illegible]. Oliver Wendell Holmes [illegible] extremity of suffering was [illegible] in the water of oblivion, and [illegible] furrow in the knotted [illegible] pain has been smoothed away [illegible]. This vision of 1846, ful- [illegible] perhaps beyond Dr. [illegible] highest hope, will, we trust, be [illegible] in the future beyond our [illegible].

[illegible] anesthesia has meant to [illegible] is vividly described by Dr. [illegible] in the address he gave at [illegible] of the monument to Dr. [illegible] Long:

> [illegible] unshackled, physicians re- [illegible] the operating table, the shrieks of [illegible] and the operating [illegible] became a place of quiet, [illegible] the ravages of disease [illegible] the knife. Conditions [illegible] were brought under the [illegible] surgeons rapidly acquired a [illegible], and exquisite skill that [illegible] the most amazing progress wit- [illegible].

[illegible] of the use of anesthetics [illegible] an outstanding event in [illegible] the world, conferring an [illegible] upon mankind.

[illegible] an attempt to convey any adequate idea of the historical richness and adventure of the developments of anesthesia. The courage of the early pioneers contributing to this work in all countries thrills our imagination and exacts our homage; but the fact that it was in this country that courage took the form of fine achievement, and such men as Crawford Long, Horace Wells and Thomas Morton first demonstrated to an unbelieving world that anesthesia could be produced and maintained throughout surgical operations, makes us conscious of a "goodly heritage," a heritage increasing in value as each succeeding legacy of fine work is added to the past. Thus we have the evolution of the first crude methods flowering into the finely developed technic of modern anesthesia. "Many grains of frankincense on the same altar; one falls before, one falls after; but it makes no difference."

Considering the supreme value of anesthesia and the richness of its historical background, one is amazed to contemplate the fact that its establishment as a separate study or science was so long delayed. The London Society of Anesthetists, founded through the efforts of Dr. Dudley W. Buxton in 1897, and the American Society of Anesthetists, organized in 1912, represent a consistent and fine effort to emphasize the importance of the work. The fact that the attitude of the American Society towards the nurse anesthetist is not favorable, should not lessen our real appreciation of the valuable contribution made to the work as a whole, and particularly of the official publication, *Current Researches in Anesthesia and Analgesia*, an excellent journal and one of great value to all interested in anesthesia.

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[1] [illegible] Other Nurses' and Nurse An- [illegible] Table, Milwaukee, June 11, [illegible]

Although the establishment of anesthesia as a science apart from but impinging on surgery is now acknowledged, some difference of opinion exists as to its limiting boundaries. If it is accepted that the surgeon diagnosing the case and advising the operation is primarily responsible for the patient's care and safety, then definite limitations are established as to the province of the anesthetist, the surgeon necessarily having the right to decide the anesthetic, method of administration, and the status of the anesthetist. This is the pivotal point, and the acceptance of this view by a goodly number of surgeons has resulted in the selection of the nurse anesthetist to administer anesthetics rather than a doctor. We have now arrived at the subject of this paper, "The Nurse Anesthetist," the reasons for her as such, objections which are made against her, present qualifications, and promise of her future greater usefulness.

When a well established method of procedure is changed, an investigation into the reason for the change, and the good faith and integrity of those advocating it, is pertinent. The established custom in larger clinics, before the advent of the nurse anesthetist, was to have a medical anesthetist available for special cases, leaving the routine anesthetic work of the hospital, necessarily including many difficult and serious cases, to an interne on the surgical service. As the interne's term of service was short, continuity of satisfactory technic was hard to establish; the specialist, being in private practice, was necessarily frequently busy at one hospital when badly needed at another. With no criticism of those involved in this system, the system itself was not satisfactory, and was changed by those concerned—the surgeons and hospitals.

Doubtless many years before definite recognition of the value of their work as such, nurses had been successfully administering anesthetics with little notice taken of it. When the Mayo Clinic appointed a nurse anesthetist, their example was followed in rapid succession by other large and well established surgical clinics; the innovation became accepted. The work of the nurse anesthetist making further appeal to surgeons and hospitals, their number increased and today we have a great many hospitals throughout the country where anesthesia is established as a definite division of hospital service, and the nurse anesthetist is recognized as particularly well adapted to carry on the work.

It was inevitable that objections to nurses administering anesthetics should arise and it is most important for us to consider carefully the originators of such objections as well as the validity of the objections, as such. Those objecting to the nurse anesthetist are not surgeons and hospitals employing them, but the medical and dental anesthetists, who feel the encroachment on their field of work. In order to clear our minds of all extraneous and non-essential considerations, we must again return to the crucial question as to who, in the final analysis, is most vitally concerned in and responsible for the safety of the patient, to say nothing of the protection of his own work and reputation; the answer must again be—the surgeon. It is inconceivable that men of the professional standing and high reputation of surgeons, who are favorable to the nurse anesthetist, should be so for any other reason than acceptance of the fact that a nurse educated in anesthesiology becomes a skillful and expert assistant.

Objections formulated against the

nurse as an anesthetist may be divided briefly into three classifications: invalid, those having no real excuse for existing other than prejudice; valid, but surmountable; valid, and insurmountable, because relating to a branch of the work clearly involving surgical procedure. Under invalid we put first encroachment into a field supposedly not belonging to them. No such encroachment is admitted. Nurses were asked to enter the field with the definite hope of improving a condition which had been under the control of specialists since 1846 or thereabouts. The second invalid reason is lack of intelligence on the part of the nurse to assimilate information concerning the subject; or if a rare few do, by chance, intelligently understand it, they are not able to impart this information to others. The nurse anesthetist is designated by various titles, such as "lay person," "nurse technician," "helper," and in one textbook we are confronted with the classification, "nurses, non-commissioned officers and other lay persons." "Serving an apprenticeship" is also a term used by medical anesthetists who have a nurse under their jurisdiction. Lack of intelligence is refuted by the fact that the nurse anesthetist has shown ability not only intelligently to assimilate the instruction given on the subject, but she has succeeded in applying this knowledge by development of technic of administration, differing in detail and varying in excellence, it is true, yet on the whole so satisfactorily established as to warrant the confidence and approval of surgeons and hospitals depending on her for the carrying on of this special work.

It has been frequently asserted that the nurse anesthetist carries out the work by "rule-of-thumb practice." Commenting on this we acknowledge the fact that in every method of procedure certain routine acts, precisely carried out, afford protection to the major operation; this has been wrongly confused with "rule of thumb," which in itself implies inexactness. Of course, nurse anesthetists carry out certain procedure in a routine manner, but no intelligently educated nurse anesthetist applies such routine methods to interpretation of phenomena produced by an anesthetic drug. Knowledge of the cause and significance of the patient's reactions under anesthesia and during surgical work is derived from information elucidated by those acknowledged capable of imparting it, such knowledge being available to both medical and nurse anesthetists.

The contention that a nurse anesthetist is incapable of imparting instruction to others is, in the face of what has been accomplished in a comparatively short time, absurd. It is the nurse educator, not the medical instructor, who has established postgraduate schools of anesthesia for nurses, on the proper basis of education, not on the basis of apprenticeship or mere technical training. A technical training may do very well for the handling of problems involving inanimate objects, but never for work involving human life; education, more of it and better in quality, is what we desire for the nurse anesthetist.

To the designation of the nurse anesthetist as a lay person, if used to indicate "not belonging to a profession" or apprenticeship as "belonging to a trade," we properly take exception. That nursing is a profession has been established and accepted. The subject has been covered in a comprehensive and convincing paper written by Miss Stewart and therefore does not come within the range of this discussion.

[illegible]

Under the second classification, valid but surmountable, we put lack of medical education. The necessary qualifications for an anesthetist range widely from practically none at all, in which case the opinion is held that administering an anesthetic requires no particular ability or special training to the opposite extreme, that the "Art of anesthesia implies an intimate knowledge of general medicine, pathology, surgery, therapeutics, psychology and special branches." In the education of the nurse anesthetist, we must seek middle ground upon which to establish educational standards.

The contention that a nurse should not be an anesthetist because of her inability to make "preliminary examinations, to properly interpret and correlate the findings of others, and direct the patient's preparation," might be regarded by some as an argument in her favor. To those who believe that a patient should be given a most careful physical examination by one especially trained in diagnosis, the idea of this being more or less hurriedly done by a medical anesthetist would hardly commend itself. It often happens that a medical anesthetist is connected with different hospitals; an emergency case coming in to one hospital, when he was engaged in another, would make it necessary for him to accept the findings of the interne, thus placing him in the same position as the nurse anesthetist. Of course having a medical anesthetist attached to one hospital, available day and night, as are internes, would partly obviate such situations, but occasions would, we fear, often arise when the duty either of administering an anesthetic or making a physical examination would necessarily have to be given over to someone else. The need of better education and improved methods of imparting knowledge, so that by creating enthusiasm for the subject the student becomes, if not a scholar, a seeker after truth, is a problem of wide significance. In this particular instance we emphasize the fact that educational requirements for this work should be defined and standardized by those most concerned—surgeons, hospitals, and educators of nurse anesthetists, who show by their attitude the desire, not to create a class of poorly instructed mechanical helpers, but to educate a group of fine women so that a work so vital in its nature and so humanitarian in its scope, will be enhanced and protected by their efforts.

An educational program implies means to carry it through. Postgraduate schools of anesthesia, already established or to be established, should be required to conform to certain educational standards, the fact accepted that a nurse before practicing this work must hold a certificate from a recognized school; following in order come state board examination and state registration.

This program, although entailing time and effort in working out, is we think the only logical plan to pursue. Its adoption emphasizes the fact that the practice of anesthesia is so important that educational standards have been established, and only nurses properly educated and giving further evidence of their ability by passing a state board examination are eligible for registration. It will also, by assuring to the nurse anesthetist her clear right to practice this art, answer the objection so often expressed, that a nurse is not legally entitled to administer an anesthetic. This in turn safeguards the hospitals and surgeons who have [illegible] [illegible] as anesthetists [illegible] [illegible] [illegible] [illegible] [illegible] and better quality of service throughout the country, and by so doing affords greater protection to all communities.

Under the same general classification of valid but surmountable objections we put economy and exploitation. It has been repeatedly stated that the nurse anesthetist is employed simply as a matter of hospital economy. These nurses are modestly paid, and the anesthesia fees accrue to the surgeons and hospitals. In other words, nurse anesthetists are exploited for others' gain. We admit, without argument, that a department of anesthesia is no place for destructive economy. Nurse anesthetists should be well paid, and expert work rewarded by increase in salary. As to exploitation, that is a more serious thing and not so easily answered, but in this particular case an analogy between the exploitation of the nurse anesthetist by hospitals, if such occurs, and exploitation by medical anesthetists, who are perfectly willing for hospitals to employ a modestly paid nurse anesthetist and ask her to assume responsibility for the daily work, allowing them to give anesthetics for patients who pay a fee, might occur to a discriminating mind. The question of inequality of remuneration between men and women or, as someone has tersely expressed it, "equal work and unequal pay," is an old one which has existed longer than it should.

Valid insurmountable objections, however, relating to a branch of the work clearly involving surgical procedures are—local, or infiltration, and regional anesthesia.

It has been stated by an authority on the subject that the use of these methods implies

> a [illegible] knowledge of descriptive and [illegible] anatomy, especially with regard [illegible] is beyond discussion. [illegible] which anyone desirous of [illegible] the study of regional anesthesia should fulfill. The anatomy of the human body must, besides, be approached from an angle hitherto unknown to the medical student and with which the average surgeon is not at all familiar.

It is therefore evident that this division of anesthesiology belongs definitely to medical specialists and is quite outside the province of the nurse anesthetist.

That the nurse anesthetist is a factor in the medical world no intelligent person will deny, and that this work is becoming more appreciated is evidenced by the increasing demand for her services. After all this is the "proof of the pudding."

Improvement of the present situation is in the hands of the nurse anesthetists themselves. If the work is to be properly safeguarded and hoped-for progress attained, it is necessary that remedies be applied to certain detrimental conditions now acknowledgedly existing. It would seem that the first step should be the awakening of deeper interest and the development of constructive leadership. Following in logical order would be: self-organization as a special division of hospital service, in such an organization emphasis to be placed on the establishment of educational standards; postgraduate schools of anesthesia, established or to be established, required to conform to an accepted criterion of education; state registration, putting the right of the nurse anesthetist to practice her vocation beyond criticism; constant effort toward improving the quality of the work by means of study and research, thus affording still greater protection to the patient; dissemination of information gained through proper channels.

Success in carrying out this forward program will depend largely on a deepening appreciation of the supreme value and usefulness of our vocation.

Mental Hospital Affiliations for General Hospital Students[1]

ANNE HOW, R.N.

THE need for such affiliations is not a new thought but has been expressed by the most outstanding members of our profession. Today, like a seed that has long been in the ground, that thought seems about to bear fruit.

The first improvement in the care of the mentally ill in this country came as a result of the work done by Dorothy Lynde Dix, and the first school for nurses in a mental hospital was started at McLean Hospital in 1879 by Dr. Edward Cowles. Miss Linda Richards, "America's first nurse" who so recently passed away, felt that "the mentally sick should be at least as well cared for as the physically sick" and spent several years in organizing training schools for nurses in state hospitals—Taunton State Hospital and Worcester State Hospital, in Massachusetts, and Michigan State Hospital, Kalamazoo, Mich.

Several very good schools in private mental hospitals have carried on through the years between the opening of McLean School and the present time, such as Butler Hospital School, Providence, R. I.; Bloomingdale School, White Plains, N. Y.; Sheppard and Enoch Pratt, Towson, Md., among others.

The Boston Psychopathic Hospital, which opened in Boston in 1912, and Phipps Psychiatric Clinic, which opened at Johns Hopkins Hospital in 1913, mark the next forward step in the nursing care of the mentally ill, being a more or less direct outgrowth of the formation of the National Committee for Mental Hygiene. The growth of this movement has been slow, but today the slowly opening door seems to be swinging wide and we look forward to much progress in the next few years, as mental hygiene is now recognized as being a part of almost every social movement. Many mental hospital schools of nursing are offering courses in mental nursing of which the general hospital schools are taking advantage.

At the first International Congress on Mental Hygiene, held in Washington, D. C., May 5–10, where six continents and fifty-two countries were represented, two afternoon sessions were given over to nursing. Dr. Edward A. Strecker, Professor of Mental and Nervous Diseases, Jefferson Medical College, Philadelphia, in his paper on "Psychiatric Education" given at this Congress, stated the various problems involved in the psychiatric education of the nurse which he considered most important. "In the average training school," he said,

> the nurses receive a few formal lectures in psychiatry. An extremely common complaint and criticism of nurses, even from excellent training schools, is that while skilled and capable in technic they lack even an ordinary understanding of the psychological features of illness. An already heavily overloaded schedule would seem to preclude any radical revision. Some improvement would be noted if, as a part of each course—medicine, surgery, obstetrics, pediatrics, and so forth—there could be given, by the department of psychiatry of the hospital, an exposition of the psychological needs of the various groups of patients. Wherever possible, the nurse should have at least some experience in the outpatient psychiatric clinic of the hospital. The practice of affiliation with mental hospitals should be encouraged. Here the student

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[1] Read at the Mental Hygiene Section, Milwaukee, June 12, 1930.

graduate nurse will usually have access to an excellent course and splendid practical experience. Unfortunately, this experience is too often confined to frankly psychotic patients. A period of out-patient service, where borderline situations and the neuroses are encountered, is extremely valuable. For the nurse who wishes to become a psychiatric nurse, a longer period of preparation is imperative. This preparation should not differ much in kind from that given to the graduate student in psychiatry, although, naturally, it will differ in degree and will be much simplified and much less detailed. For the nurse who aspires to the more particularized and technical aspects of psychiatry, there should be a working apprenticeship under a psychiatric specialist, in the child-guidance clinic, in the laboratories, and in other fields. There has not been much utilization of nursing potentialities in these directions.

Dr. Clarence B. Farrar, of Canada, in discussing Dr. Strecker's paper, stressed:

1. Affiliation of mental hospitals with general hospitals and of general hospitals with mental hospitals.
2. Clarity of teaching programs between the two.
3. Uniform training for all schools of nursing.
4. Psychiatric training for all schools of nursing.
5. Elimination of stigma on mental disorders.
6. Removal of feeling between somatic and mental disorders.

In planning the three months' course in mental nursing at the New Jersey State Hospital at Greystone Park, we had the coöperation of everyone concerned—the Commissioner of Institutions and Agencies of New Jersey, the Board of Managers of the Hospital, our Superintendent, our Clinical Director, the Directors of our Mental Hygiene Clinics, of Social Service, of Occupational Therapy, of Physical Education, and the Educational Adviser of the New Jersey State Board of Nurse Examiners. They have all given valuable aid and support. Our classrooms and teaching equipment are approved by the State Board of Nurse Examiners and the hospital furnishes excellent clinical material.

The general hospital schools are interested and, at present, we have five schools sending students to us. The first affiliation was arranged with Mercer Hospital School of Nursing, Trenton, New Jersey, which sent students to us in September, 1928. Each group of students is replaced by the same number of students from the home school every three months. At present we have the following affiliations with New Jersey schools:

5 students—Mercer Hospital, Trenton.
5 " Mountainside Hospital, Montclair.
2 " Orange Memorial Hospital, Orange.
3 " Newark Memorial Hospital, Newark.
3 " Jersey City Hospital, Jersey City.

The students are given two weeks' service on the admitting wards, the active or disturbed wards, the surgical and medical wards, the uncoöperative and convalescing wards, and the chronic wards. The service is short, but it seems desirable to give the student some experience in the observation and care of the different forms and degrees of mental illness. Instruction is given by lecture, demonstration, class discussion, clinics and ward teaching.

Our difficulties have been many, and they began when we tried to find an instructor in mental nursing properly prepared for the work. There were many applicants for the position, but on investigation they would be found unprepared for the teaching and for the supplementary classes required to follow the doctors' lectures. We were particularly fortunate to have one of our own recent graduates who had the proper background for teaching, plus interest and loyalty to her school. She has been and is continuing her preparation for teaching by summer school and extension work at Teachers College, Columbia University.

Another recent graduate of our school, especially interested in hydrotherapy, was given three months' training with a graduate hydrotherapist and has taken over that branch of the teaching. She is having a four months' course at Battle Creek, in hydrotherapy and massage, to perfect herself in this work and to improve the course given to the students here.

Another problem we have had to meet is proper record forms, both for the affiliated students and for our own. We have worked out a form which at present seems to meet our need and is an adequate, understandable record for the home school of the affiliated student.

Our housing is a problem at present, with the increase in our own school and in the affiliated group, and we have come to the place where we cannot accept more schools for affiliation, but we have every reason to believe that this need will be met in the not too distant future.

The problem of an adequate nursing staff is the most difficult one we have. The graduate coming from a general hospital without knowledge of mental nursing is nearly always a problem, not a help. She is at a distinct loss, she does not know what to do with herself or for the patients. We feel that this will be overcome when we graduate more nurses and as more affiliated students are graduated from their home schools.

We feel that the student who has the privilege of some mental training is given a broader understanding of human conduct in the opportunity to observe behavior without the ever conscious check required to meet the standards of society. We feel she will be better able also to make her own adjustments to ever changing environment, and most important of all, she will be able to see her patient as a whole, both the physical and mental sides.

The contact with students from general schools has been of great benefit to our students, stimulating a healthy spirit of rivalry. The students who have had the affiliation here tell me that they are making better adjustments of their own problems and I think they feel its value, several students having extended the time of their training from six weeks to two months in order to take advantage of this course.

* * *

Patients Will Avail Themselves of Psychiatric Facilities

"WHEN it becomes known that patients with early nervous symptoms may, to a considerable extent, be treated in general hospitals having psychiatric facilities in practically the same way as other hospital patients, nervous and mental patients will undoubtedly be quite willing to go to a general hospital for study and treatment at a stage when considerable help can be provided, although they are often unwilling to enter voluntarily a mental hospital even for temporary treatment. Under skilled treatment, in the psychiatric section of the general hospital, many of these would make a good recovery and be returned to their homes and friends without [illegible]

[illegible]

S. Lillian Clayton[1]

BY ANNIE W. GOODRICH, R.N.

I HAVE been asked to speak to you this evening of one whom the world, reading with the most superficial understanding of the tasks implied by the posts she held and her truly extraordinary achievements, would inevitably acclaim as a great nurse administrator, leader and teacher. All of these she was in fullest measure, and yet I think that the portrait emerging through such characterization fails, fails utterly, to reproduce the personality we knew as Lillian Clayton.

In so thinking I have recalled the thoughts of a Syrian poet concerning the personality of Jesus, or rather his conception of the thoughts of those who knew and loved him, and some of these I have brought to you with the hope that through them you who knew her might find comfort, and those who did not may have some conception of the type of person we who knew her felt her to be.

Could you conceive a majesty too kind to be [illegible]? And a beauty too radiant to seem beautiful? I would speak of his face, but how shall I? It was like night without [illegible] and like day without the noise of day. It was a sad face and it was a joyous face. Could you hear in your dreams a voice [illegible]? And he was gentle [illegible] of his own strength. His [illegible] and held other minds and his [illegible] visited other spirits. And in [illegible] changed these minds and [illegible] seemed miraculous, but with [illegible] simply like breathing [illegible] every day.

[illegible] with the daffodil and the [illegible] awake the spring[illegible] like a mountain in the wind. [illegible] the sharp [illegible]. He would even be silent [illegible] for he was strong and the [illegible]. But there was also impatient. He was impatient with those who weighed and measured the day and night before they would trust their dreams to dawn or eventide. Jesus was patient. Yet he was the most impatient of men. He would have you weave the cloth though you spend years between the loom and the linen. But he would have none tear an inch off the woven fabric.

One man longed for a kingdom in which he was to be a prince. Another man desired a kingdom in which all men shall be princes.

All this I say that you may understand not only in the mind but rather in the spirit. The mind weighs and measures but it is the spirit that reaches the heart of life and embraces the secret; and the seed of the spirit is deathless.

The wind may blow and then cease, and the sea shall swell and then weary, but the heart of life is a sphere quiet and serene, and the star that shines therein is fixed forevermore.

His mind sought and held other minds and his complete spirit visited other spirits. And in so doing his spirit changed these minds and these spirits. It seemed miraculous, but with our Lord and Master it was simply like breathing the air of every day.

"I have seen her," said Dr. Doane, "lead the sick pupil nurse by the hand into eternity as she would lead her on duty on the ward." There is no question of the pervasive, enduring and far reaching influence of that quiet, forceful personality on the great, ever changing student body with which she came in daily contact, and her association with whom she felt to be so sacred. I recall that she spoke to me once at great length in the matter, saying that she would never allow the day to come that separated her from her pupils. Nor will she ever be separated from them, for woven into the fabric of their lives are the wonderful threads of her own. Far beyond her own students did that influence extend. Hundreds from other schools have come under her wise guidance, while through the three score or more nurse fellows selected by the Rockefeller Foundation in the past few years for advanced study in this country, that influence has been carried directly throughout the world,—to Brazil, Bulgaria, China, Czechoslovakia, Denmark, Finland, France, Hungary, Ireland, Japan, Jugoslavia, the Philippines, Poland, Roumania, Scotland and Siam. The care of the sick in all these countries will reflect the principles that she sought for her beloved profession.

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[1] [illegible] memorial service for Miss [illegible] St. Paul's Church, Milwaukee, [illegible]

And altogether beyond us is a measurement of the influence of the skilled touch, the passing glance of encouragement or sympathy, of approval or correction that was her daily gift to the many thousands of patients and workers during those years within the hospital walls.

Jesus was patient with the [illegible] and the [illegible] even as the [illegible] [illegible]. He was patient with a [illegible] in the [illegible]. He [illegible] with [illegible] of his face. He would [illegible] [illegible] [illegible]. [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] were patient. Yet he was the most [illegible] of men. He would [illegible] [illegible] [illegible]. But he would not [illegible] [illegible] of the [illegible] force.

She would not forget [illegible] her memory [illegible] were the years of the [illegible] at Blockley, established in [illegible], which she [illegible] in [illegible], its [illegible] and [illegible]. She saw [illegible] [illegible] the [illegible] [illegible] in the [illegible] and [illegible] of the [illegible] which [illegible] by [illegible] and [illegible]. [illegible] than that, [illegible] to the community [illegible] companion of the [illegible]. And when the call came she was like one transfigured, and she embraced as would a mother her crippled child the terrible burden of human suffering, imposed by the dual appointment of Superintendent of Nurses and Director of Nurses of the Bureau of Hospitals,—the General Hospital with 2,000 beds, the Contagious with 1,200, the Mental with its 4,000. With an endurance incredible in so frail a body and a force undreamed of in so gentle and retiring a personality, she put herself to this task so stupendous as is the measure of her achievements. Of those years of labor Dr. Doane said at the dedication of the tablet memorializing her work:

> When one looks at a life of this sort one wonders at the motive that underlies it. During the past fifteen years I have wondered what was the compulsion that made possible day in and day out, year in and year out, for [illegible] years, a service so forgetful of self, without any visible evidence that would [illegible] it so, and I think I know the answer. I think her goal, by day and by night, has been the individual patient and [illegible] of [illegible]. . . . I cannot [illegible] her without [illegible] the high principles of education and the [illegible] facing of difficulties, because those principles are right.

Let us listen to her in this matter through her Presidential address in [illegible]:

> As we look back over the years, our great [illegible] [illegible]. The [illegible] of [illegible] the [illegible] whole [illegible] and [illegible] the [illegible]

[illegible] *Ethics* is as true today as it has [illegible] "Ethics is but another name for [illegible] (or right doing), that for which [illegible] in every generation have [illegible] striven, without which life [illegible]." . . .

[illegible] should consider the importance [illegible]. Find someone in your [illegible] with native powers of leadership, [illegible] you can to help in her [illegible], and if such a one be found let [illegible] the development of her own abili[illegible] unfailing to accept the responsi[illegible] upon her by the members of her [illegible] having accepted it to carry it [illegible] completion. Let her not be afraid of [illegible]. Last but most important of all, let [illegible] that nursing was introduced in [illegible] because patients needed nurses. [illegible] need nurses today. The need is [illegible].

[illegible] a portrait of herself. As one [illegible] the interests and activities [illegible] of her own demanding [illegible] she gave thought and [illegible], one is bewildered by their variety, [illegible]ity and obvious importance, [illegible] bearing the indelible [illegible] of her constructive mind. [illegible] into the demand these [illegible] made upon her is given [illegible] Dunlop speaking of her [illegible] the State:

[illegible] realizes that Miss Clayton, as [illegible] of the State Board of Examiners, [illegible] gave every month to that [illegible] and for the last three years [illegible] in the morning to take a 5 [illegible] arriving in time [illegible] in the [illegible], going to the [illegible] a few minutes for lunch, [illegible] perhaps stopping [illegible] until the [illegible] it is not an eight-[illegible] of love.

[illegible] *for a kingdom in which he* [illegible] *Another man desired a* [illegible] *one shall be prince.*

[illegible] experience of [illegible] appearance at criti[illegible] of the [illegible] for the [illegible] of [illegible]. I am not unaware that there are those who see such personalities as creating rather than created-for. But whatever may be the accepted philosophy, shapers they are indeed of the desired plan, and of the lives concerned therewith. Never was there a field that so justified its preparation for the seeds of a new social order as did those great municipal hospitals, or that offered greater opportunity for experimentation. Never was a leader more divinely attuned for the undertaking—seeker of knowledge, lover of beauty, believer in action. Writes Dr. Dewey in his *Quest for Certainty:*

> There are three ways of idealizing the world. There is idealization through purely intellectual and logical processes, in which reasoning alone attempts to prove that the world has characters that satisfy our highest aspirations. There are, again, moments of intense emotional appreciation when, through a happy conjunction of the state of the self and of the surrounding world, the beauty and harmony of existence are disclosed in experiences which are the immediate consummation of all for which we long. Then there is an idealization through actions that are directed by thought, such as are manifested in the works of fine art and in all human relations perfected by loving care. The first path has been taken by many philosophies. The second while it lasts is the most engaging. It sets the measure of our ideas of possibilities that are to be realized by intelligent endeavor. But its objects depend upon fortune and are insecure. The third method represents the way *of deliberate quest for security* of the values that are enjoyed by grace in our happy moments.

It was through this third idealization, "actions directed by thought in all human relations perfected by loving care," that Lillian Clayton's life was expressed, and how consistent was that expression. For her great tasks that demanded knowledge, experience and imagination, native ability with the will-to-do was not sufficient.

A most cursory view of her program of education reveals the preparation through which she strengthened, enriched and directed her talents: public and private schools, a course in business education, a year of training at the Children's Hospital, the course in the Philadelphia General, a course extending over two years at the Baptist Institute of Christian Workers in preparation for the mission field, a student in Teachers College in 1910 and again in 1911, an instructor (than which there is no more assured method of securing and fixing knowledge) in the summer session at Teachers College in 1922. The briefest enumeration of the posts she held bears witness to the effective application of that she had acquired: President of her Alumnae Association; of the Philadelphia League of Nursing Education; of the National League; President of the Board of Directors of the *American Journal of Nursing;* President of the Pennsylvania State Board of Nurse Examiners; member of the Committee on Nursing of the Council of National Defense during the war; member of the Board of Directors of the International Council of Nurses; President of the American Nurses' Association, and representative of this Association at the Interim Conference of the International Council of Nurses; student of nursing conditions in Europe at the request of the Rockefeller Foundation. And through all and above all these varied and persistent demands upon her, she never lost sight of her great objectives, nor the means alone through which the believed objectives could be attained: "We must find," she says, "a way to make universally real the ideals which we have. We must reach the objectives which we believe to be ours."

With almost meticulous care and precision she drafted a plan of required accomplishments in that great municipal hospital, accomplishments that year by year were achieved with truly astounding accuracy and completion. No words of mine can so vividly bring before you the picture of that great life tapestry, in the design of which Lillian Clayton played so potent a part, as the outline sent me by her beloved colleague, Miss Kay, of the required and attained objectives blocked out year by year,—its terse presentation clarifying rather than obscuring its truly sublime message.

Outstanding Points of Development in Philadelphia General Hospital

January 1, 1915	*1930*
The object was to do away with patient help throughout the institution, placing all employees on salary.	This has been accomplished.
To improve the physical condition of patients throughout.	This has been and is being accomplished. Within the next eighteen months all Departments will be in new buildings according to the plans.
To educate the public as to the needs, and development of the hospital, and to get their cooperation.	Much has been accomplished along these lines.
To bring all patients, including mental and chronic patients, under the supervision of nurses.	This has been accomplished with the exception of the Men's Venereal.
To bring all preparation of food under the supervision of dietitians. There was one housekeeper in 1915.	This has been accomplished. There is a staff of seven dietitians at the present time.

The development of the Physio- and Occupational Therapy and the Social Service Departments.	These departments have been established and are active.
The improvement of living conditions for the nurses.	This has been accomplished. Two new buildings have been added.
To increase the salaries of graduate nurses which ranged from $25 to $40 per month.	The present salaries for the graduate staff range from $72 to $150 per month.
To increase the graduate staff, which was twenty.	This has been accomplished. The number has been increased to 156 graduates.
To increase the number of students allowed, which was then ninety regular, and six affiliating, representing two schools.	The number of regular students has been increased to 325, and there are now 140 to 150 affiliating students representing twenty schools.
The development of the educational system for nurses. At that time there was no full-time instructor.	At the present time, there is an educational director, with eight full-time assistants, and clinical subjects are being taught by supervisors from the Departments. A full-time stenographer is included.
At that time the teaching equipment was one classroom, a broken blackboard and a few chairs.	At the present time, there is a teaching suite of eight rooms. The teaching equipment is abundantly adequate.
There was no reference library.	At the present time, there is a library of one thousand volumes with a full-time librarian.
There was no health or social director.	At the present time, there is a full-time health and social director, with definite improvement in health reports.

The plan for the next two years was to improve the quality of the nursing service given to the patients on the ward, and to improve the ward teaching for the student, also to gradually equip the remainder of the new buildings and to have them completely staffed with graduate nurses, attendants, orderlies, maids and janitors.

How shall we interpret Lillian Clayton's life?

All this I say that you may understand not only by the mind but rather to the spirit. The mind weighs and measures, but it is the spirit that reaches the heart of life and embraces the mystery; and the seed of the spirit is deathless.

Here is indeed the key. She was predominantly spiritual. What she brought to this earth is enduring. Through the aeons of time the children of the world will continue to reap the harvest of her sowing. She saw the glorious wings of the spirit fettered by the warped body and she saw the beautiful body scarred and deformed by faulty environment. And she demanded of herself close and continued proximity to a field where through observation, experiment and above all unswerving devotion to the task at hand she might find the answer.

The wind may blow and then cease, and the sea shall swell and then weary, but the heart of life is a sphere quiet and serene, and the star that shines therein is fixed forevermore.

The Durable Satisfactions of the Nurse's Career[1]

GLENN FRANK

I FIND a singular satisfaction tonight in discussing some of the major aspects of the nurse's career, for that career seems to me to offer to the women capable of answering its full challenge, a life in which personal satisfaction and public service meet and merge. I make no apology for putting personal satisfaction ahead of public service, for the highest public service cannot be rendered by dissatisfied servants. The utmost efficiency of service is impossible unless in the service a life of durable satisfactions is possible.

If we cannot find the durable satisfactions of life in our work, there is small chance that we shall find them outside our work. Humanity has long been hag-ridden by the ancient tradition that work is a curse. We are all too likely to turn to toil as to the serving of a sentence, and to look for happiness behind the [illegible] walls of leisure. A great gulf is too often fixed between the work that fills our stomachs and the [illegible] that move our souls. It is beginning to dawn on us that this is all wrong. Happiness cannot be switched on like an electric current after the day's work is done.

In these days of [illegible] specialization, it is no easy matter for the average young woman to find a career from which she may derive a high personal satisfaction and in which she may render a helpful public service, a career that is at once a means of self-support and a [illegible] of self-expression. But the work of the [illegible] trained nurse seems to me to fill the four basic requirements of such a career.

First, the work of the trained nurse has difficulty enough in it to give one a sense of adventure while doing it and a sense of mastery when it is done.

We are happiest when we can find in the work out of which we are making our bread and butter a moral equivalent for that sense of adventure and hunger for conquest that we have inherited from our primitive ancestors. A party of explorers leaves the comforts and conveniences of their metropolitan clubs and faces gaily the possibility of going to their graves in polar ice. A distinguished professional man prefers the perils of mountain climbing to the safety of his summer home by the sea. When, now and then, these men fall afoul of bad fortune and pay the price of adventure with their lives, we turn from the report of their death and say: Why will men do such foolish things? We forget that man is rational only about certain things and only at certain times. Man's impulses are very old. Man's intelligence is very young. We are still moved by the memory of [illegible] when the world was young and the race in its infancy.

[illegible] climb [illegible] and [illegible] is [illegible] his [illegible] as a [illegible] for [illegible] we [illegible] the [illegible] of [illegible]

[illegible] little [illegible]

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[1] An address given at the [illegible] of the biennial convention of the three national nursing organizations, at Milwaukee, Wis., June 6, [illegible]

[illegible] too long in an office with routine [illegible] his constant companion and [illegible] will grow chill. Lash him [illegible] job and the call of the [illegible] will begin to sing in his brain [illegible] will set out on some seemingly [illegible] adventure. I suspect that [illegible] are more interested in the [illegible] of discovery than in the [illegible] of discovery. If we [illegible] have eavesdropped their hearts, I [illegible] we would have found Peary [illegible] more attracted by the North Peril than by the North Pole. [illegible] brave dangers in order to [illegible] heads, but to keep their [illegible] breaking under monotony.

[illegible] who are in the midst of an [illegible] I can but observe from the [illegible] I am sure I do not need to [illegible], in the part *it* is playing [illegible] warfare against disease, the [illegible] of nursing offers a moral [illegible] for that impulse to adventure [illegible] dangers and that hunger [illegible] conquest of difficulties which [illegible] inherited from our primitive [illegible]

[illegible] *the work of the trained nurse* [illegible] *routine and variety mixed in* [illegible] *proportions.*

[illegible] of routine and [illegible] to a career in which [illegible] are to be found. [illegible] all routine, we would [illegible] paralysis. If our work [illegible], we would die of spirit- [illegible] In work as highly [illegible] you can have some- [illegible] joy in the very [illegible] And you [illegible]

[illegible] *of the trained nurse means continuous contact with congenial associates.*

If we are to find the durable satisfactions of life inside our work, congenial associates are an important consideration in the choice of a career. Medicine attracts many of the most interesting minds of our time. The nurse enjoys contact with the men and women who are making the art and science of medicine one of the most alluring and exciting fields of exploration and service in modern life. And, while I have heard that all patients are not equally congenial, your sick-room ministry does at least bring you into contact with the whole range of human personality from the peasant to the prince. I do not know a career now open to young women in which, by and large, the human contacts and associations are more satisfying.

Fourth, *the work of the trained nurse gives her the opportunity to create something she can claim as a personal accomplishment.*

It is futile to expect to find the durable satisfactions of life in any work that does not mean something more than the deft use of a bag of technical tricks that can be learned once and for all. An able and active mind must have the chance to unleash its creative powers. Entirely aside from the service she renders in the technical routines of the sick room, the nurse has the chance to make two important contributions to medical service, in the making of which she may find a deep personal and professional satisfaction.

In the first place, *the nurse can help materially to restore the now somewhat disturbed balance between the science of medicine and art of medicine.*

The nurse has an even more sustained opportunity than the physician has to foster the finest in the art of medicine at a time when the science of medicine sometimes tends to overshadow its art. The world of medicine is in a turmoil of change. As I suggested at a recent session of the American College of Surgeons, the historian of medicine will look back upon the period following, say, 1875, as the time of the Medical Revolution, just as the historian of industry looks back upon the period following, say, 1770, as the time of the Industrial Revolution. Let me suggest in a bit more detailed fashion what I mean.

Before the Industrial Revolution, the making of goods was in the hands of the old handicraftsman. With him the making of goods was an art. Steam and machinery came along and radically changed his world. We would not, if we could, turn back the clock and destroy our factories. But we are increasingly aware of the fact that, in shifting from the art of production to the science of production, we lost many virtues and values that the old handicraftsman had created. We suspect that, if our foresight had been as good as our hindsight, we could have managed the Industrial Revolution a little more wisely and have had with us today both the quality of the old hand production and the quantity of the new machine production.

The same sort of readjustment is now in process in the field of medicine.

Before the Medical Revolution, the cure of disease was in the hands of the old doctor, the general practitioner, the family physician. With him the practice of medicine was an art. And then the science of the study of disease came along and radically changed his world. We would not, if we could, turn back the clock and destroy our laboratories. But we are increasingly aware of the fact that, in shifting from the art of medicine to the science of medicine, we are in grave danger of losing many virtues and values that the old doctor created. If we manage this Medical Revolution wisely—and there is yet time, for it is just getting into full swing—we may preserve both the human values of the old medicine and the scientific values of the new medicine.

Medicine is both an art and a science. The old doctor of the prescientific era had many deficiencies, but according to his light, he was an apostle of the art of medicine. He may have been poor in scientific information, but he was rich in human insight. He may have been awkward in handling test tubes, but he was adept in handling patients. He knew, without having to learn it in laboratory or lecture room, the subtle interdependence of mind and body. His sick rooms were secular confessionals in which he practiced a rare priesthood. He was a psychoanalyst before the days of psychoanalysis.

We cannot afford to flout the memory of the old doctor. Scientific medicine must perfect his technic and widen his knowledge, but it must not lose his spirit. We must marry the old doctor's interest in the diseased to the new doctor's interest in the disease. I do not think I am theorizing impractically by suggesting that the nurse, if her mind is big enough, her training broad enough, can do much to further this fusion of the old art of medicine with the new science of medicine.

In the second place, the nurse can *[illegible] to the doctor's [illegible] chemistry of the patient's body a more [illegible] [illegible] to the patient's [illegible].*

I realize that I am here [illegible] on [illegible] ground. A lay listener or a [illegible] reader is likely to mix my meaning with the [illegible] of Coué. So let me be very explicit. Coué is dead, but his cry for release from despair and disease is eternal. And that is why the Coués of history have never lacked followers. Mankind has always sought and will always seek short cuts to health and happiness. Men like to believe that they can scale the heights of happiness and reap the rewards of health by the simple device of counting the beads of some secular rosary as they say, "Day by day in every way I'm getting better and better." Now there is both value and viciousness in the formulas of these "glad men" of the healing art. There is value in their formulas when they result in the release of those recuperative powers of the mind which lie so largely unused in the life of the average busy modern. That the mind can play a real part in the healing of the body is confessed by even the most materialistic. There is some subtle chemistry of the spirit that can actually effect new combinations of forces in the body.

Of course, when men are sick in mind or body, they are least on guard against quackery. The sick man will clutch at catchwords that would leave him cold were he well. But that should not blind us to the fact that there is a spiritual engineering by which the mind can marshall the recuperative powers of men into action, and as long as the Couéisms of healing confine themselves to this job they are as [illegible] a part of scientific medicine as the administering of an anesthetic. When they assume the rôle of spiritual magic they are dangerous. It is all right to call the subconscious mind up out of the cellar and make it the servant of our lives, provided only that in so doing we do not [illegible] the conscious mind down [illegible]. It is all right to [illegible] our emotions, if we do not [illegible] reason in the process. [illegible] scientific medicine [illegible] part of its function to be [illegible] science of the realistic powers of recuperation resident in man. Here, I suggest, is a point at which the nurse may, if she is equal to the challenge, make an important contribution to modern medical practice.

I have tried to suggest that the profession of nursing is something more than a glorified maid service. By virtue of its strategic position in the field of medical practice, it takes its place among the accredited professions. And this means that sooner or later society must give to the professional education of nurses the same serious consideration it has given to the professional education of doctors, lawyers, and engineers. The education of nurses calls for something more than the scraps of a hospital staff's spare time. *The training period for the profession should not be left as simply a source of cheap labor for hospitals.* We should remove every temptation to prolong the period of training beyond what is actually necessary for the conquest of the basic materials and technics of the profession. And our program of training must recognize the social necessity for different professional levels inside the nursing profession. We must train very broadly and richly those nurses who are to bring leadership to the whole field of professional training. Society must provide well for the training of nurses for the specialized field of public health service. And our great educational centers must coöperate with the vast array of small hospitals in the development of better training programs for that army of less highly trained nurses for whom a distinct public need exists.

But, all this aside, I congratulate you upon being members of a profession marked by public service and personal satisfaction, a combination that enables you to find the durable satisfactions of life inside your work.

Our Contributors

[illegible] E. Thompson, R.N., is one of the [illegible] [illegible] in the Alumnae of Presbyterian Hospital School of Nursing, Chicago. She is Director of Nursing and [illegible] [illegible] and Professor of Applied [illegible] at the University of Oregon, and has given many years of service on the Pacific Coast.

Dr. George Gray Ward is Chief Surgeon at the Woman's Hospital, New York City.

Anna D. [illegible], R.N. ([illegible] Hospital School of Nursing, New York) is Superintendent of Nurses at the Memorial Hospital, New York City, which is doing an [illegible] [illegible] work in the care of cancer patients.

Walter D. [illegible], M.D., who prepared the article on "Spinal Anesthesia" especially for the Journal, is Instructor in [illegible] Surgery at Post-Graduate Hospital, New York City.

Margaret [illegible], R.N., is Operating-Room Supervisor at the Akron City Hospital, Akron, Ohio.

Katherine E. [illegible], R.N. (St. Michael's School of Nursing, Grand Forks, N. Dak.) is [illegible] the [illegible] in Colorado.

[illegible] J. [illegible], R.N. (St. Luke's Hospital School of Nursing, New York City) is an [illegible] private duty nurse.

Lucy [illegible] Van [illegible], R.N., Registrar of the Official Registry, First District, Chicago, Ill., recently visited the [illegible] [illegible] in the [illegible] part of the country in an effort to expand her own thinking.

[illegible] L. Collins, R.N., is the able Registrar of the Official Registry of District 14, Brooklyn, N.Y.

Marion B. [illegible], R.N., is Supervisor of [illegible] at the Children's Hospital, Akron, Ohio.

Robert E. Neff is Administrator of [illegible] [illegible] and [illegible] [illegible] [illegible] the University of Iowa Hospitals, Iowa City, Iowa.

As announced last month, Shirley C. Titus, R.N., M.A., has resigned the position as Director of the School of Nursing at the University of Michigan, [illegible] she has worked with [illegible] [illegible] of graduate nursing, to become Dean of the reorganized School of Nursing at Vanderbilt University, Nashville, Tenn.

M. Josephine [illegible], Secretary of the Central Committee on Nursing, Cleveland, Ohio, has long been associated with nursing activities and was at one time Associate Editor of the Public Health Nurse magazine.

We are indebted to [illegible] I. [illegible], R.N., B.S., of the Western Reserve School of Nursing faculty and co-author with Miss Broadhurst of "Bacteriology for Nurses," for the study of [illegible] [illegible].

[illegible] C. [illegible], R.N. (Lakeside Hospital School of Nursing, Cleveland, Ohio) is Director of the [illegible] course in anesthesia at Lakeside Hospital.

Mrs. Anna [illegible], R.N. (Butler Hospital School of Nursing, Providence, R. I.) is Superintendent of Nurses, New Jersey State Hospital, Greystone Park, N. J.

Dean Goodrich, with penetrating insight has not only [illegible] [illegible] a great [illegible] but has also provided a pattern of life for [illegible] [illegible].

The particular note in Dr. Glenn Frank's address is of [illegible] [illegible] because he is President of the University of Wisconsin.

Elizabeth C. Burgess, R.N., M.A., President of the National League of Nursing Education, [illegible] [illegible] [illegible], went to the [illegible] of an [illegible] [illegible] in her presidential address on "Developing Potential Leaders."

As [illegible] [illegible] [illegible] Marion [illegible], R.N., B.S., is well qualified by her work [illegible] [illegible] [illegible] of the [illegible] [illegible] [illegible] [illegible] the [illegible] [illegible] [illegible] of New York [illegible] [illegible] [illegible] [illegible].

[illegible]

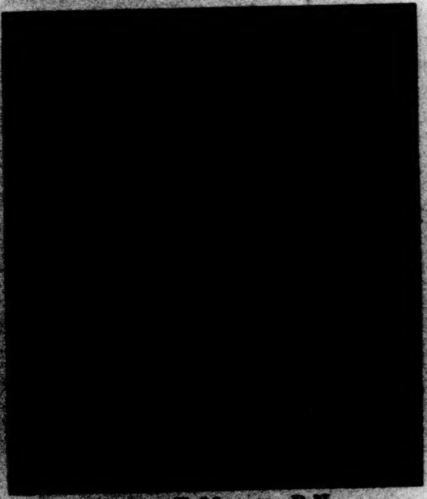
Some Specialists

Helena T. Mahony, R.N.

ANNE A. STEVENS, R.N.

OUT of the more general use of muscle reëducation that followed the poliomyelitis epidemic in 1916, has come some outstanding nursing work in the after-care of polio. Helena T. Mahony, until recently at the Georgia Warm Springs Foundation, has made a great contribution to this nursing.

When the epidemic came Miss Mahony was a member of the staff of the Brooklyn Visiting Nurse Association. Before that she had spent several years in private duty and institutional nursing, after two courses in general hospitals following her graduation from the Medfield State Hospital School of Nursing in Massachusetts.



Helena T. Mahony, R.N.

[illegible] her polio work by taking [illegible] in muscle reëducation [illegible] time that she was doing and supervising that work for the Brooklyn Association. So [illegible] number of nurses could [illegible] number of patients, [illegible] taught mothers to do [illegible] which, in Boston, Dr. [illegible] evolved that method of [illegible] patients, had trusted [illegible] trained nurses and [illegible] physical education. Not [illegible] of that task was encouraging the mothers to persist with the time-consuming exercises.

When Miss Mahony went to the New York State Department of Health she found new problems and greater responsibilities. During the war, when doctors were few, she devised the "rachet splint," to take the place of plaster casts and other cumbersome devices to prevent toe-drop and calcaneus, that is now so widely used because of its adjustability, easy application and economy.

She perfected a technic for teaching balance and crutch-walking with braces, corsets or plaster jackets, so

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[illegible] that three-tenths per cent [illegible] and about forty [illegible] from polio- [illegible] new patients.

as to get patients on their feet as soon as possible. This meant great care to protect returning muscle power and to prevent the development of deformity or of bad habits in the use of muscles. It has kept many an adult patient, harassed by economic pressure, from going to a quack or from getting hopelessly discouraged by the longer rest and more gradual return to activity, originally taught by Dr. Lovett and resulting in a slower restoration of function that may be more nearly normal. This technic is just as great a boon to patients who must use crutches after the ideal period of rest as it is when they are used earlier, as an expedient. Such ability to adapt the ideal, as learned, to the practical need of the individual patient requires not only initiative and ingenuity, but also an understanding of the patient as a human being with more needs than physical care, and that judgment which comes only after much study and experience.

Mindful of Dr. Lovett's prophecy that some day we should do our exercises under water and get better results, Miss Mahony secured the use of two Y. W. C. A. pools and taught the swimming instructors to give the exercises to the polio patients. This was the beginning of her work with water exercises now so well known.

When the doctors returned after the war, Miss Mahony took additional courses in corrective exercises and later secured further experience as a nurse physiotherapist working with orthopedists in the care of private patients. Then she went with Dr. LeRoy Hubbard to the Georgia Warm Springs Foundation to help develop, in the warm, buoyant spring water, those water exercises that would most quickly restore muscle power.

There, in less than four years, has been organized a daily régime, variously prescribed for each patient, of water exercises, swimming, sun baths, rest, walking instruction on ramps with hand rails and on specially constructed stairs, motoring, horseback riding, golf and tennis. This work is so well organized that the patients' days are filled with purposeful activity that soon creates a cheerful self-dependence and helps to bring improvement in muscle power and in "spirit power."

To measure Miss Mahony's contribution to this piece of work is impossible. She and Dr. Hubbard have worked together as only two people with a single purpose can work. In the beginning she was nurse, physiotherapist, housekeeper, buyer, house mother and even general handy man in emergency. At the same time the muscle exercises were being modified for use in the buoyant water and a staff of physiotherapists was being selected, inspired, and taught as the number of patients increased. That same initiative and practical ingenuity in adapting knowledge, skill and ideals to new situations, that patient persistence in surmounting difficulties, that appreciation of the needs of the patient as far more than physiotherapy for paralyzed muscles, which made her earlier work conspicuously effective, has helped to make Warm Springs a place for the successful treatment of patients who have had poliomyelitis.

Such accomplishment is, at the same time, the reason for, and the result of, a wise specialization that builds—on a broad general foundation—skill and judgment in one field, by concentrated study and experience in that field.

Editorials

The Convention

IT was a great convention! Opinion on the subject seems to be unanimous, for even the weather cooperated in its perfection. The extraordinarily smooth-running machinery set up by the Wisconsin nurses under the leadership of Cornelia Van Kooy, President, through many months of patient and farseeing committee work, provided a perfect setting for the splendid programs, both professional and social. Every nurse who travelled to Milwaukee enjoyed the results of their labors, but only seasoned convention-goers can really evaluate the perfection of the work of Anna K. Rice and those who, having had the wisdom to appoint her Chairman of the Local Committee, worked wholeheartedly with her.

The Program Committee, with a basic concept of "the patient and the community," produced an integrated program which contained meaty substance for practically every type of nurse. No thoughtful nurse could go hungry away. The papers and addresses were of unusually high quality. From Dr. Frank's "Durable Satisfactions" on the opening night to Dr. [illegible]'s "Functions and Organization of [illegible]" on the League's closing [illegible], they showed very clearly the [illegible] and growing tendency to [illegible] methods of evaluation [illegible] and procedures of administration, teaching and practice in all [illegible].

The immortality of a great soul was everywhere apparent. Miss Goodrich's genius for combining the inspirational and the practical was never more beautifully demonstrated than in her glorious memorial to Miss Clayton on Sunday night. Dr. Doane's profoundly moving tribute on the occasion of the presentation of the Saunders Medal brought spiritual exaltation to every hearer. But day by day Elnora Thomson, wearing with dignity and humility the mantle which had fallen so swiftly upon her shoulders as First Vice President, steadfastly showed by her every gracious act, many in commemoration, that the soul does not die. Never was one of our presiding officers faced with more difficult problems. The American Nurses' Association ticket presented for President the names of two women equally well known in their respective geographic areas, but equally little known in other areas. A vote threatened a deadlock. Miss Thomson, First Vice President, was prevailed upon to let her name be put in nomination. She was subsequently elected to the Presidency, but not before Miss Van De Vrede and Miss Gladwin had graciously and magnanimously withdrawn their names. These two were then nominated for the position of First Vice President. A deadlock resulted and was broken by Mary Gladwin's swift withdrawal because she believed the South should be represented on the Board. Situations like that may be difficult but were not. We think that fine spirits were strengthened by that shining spirit whose visible presence is no longer with us. Certainly all worked together in order that nurses and nursing might be served.

Important issues were presented for discussion. Patiently, time after time, Carrie M. Hall, Chairman of the Relief Fund Committee, went over the essential points in the proposed plan, which is published elsewhere. Arguments pro and con were presented freely, without heat but with much light. The importance of further study was clearly demonstrated. Private duty nurses spent many hours in discussion of serious problems. Definite resolutions were presented by the Private Duty Section to the Board. The matters presented are so important that we understand they have been referred to a special committee for still further study.

Legislation attained a new prominence, for the results of the work of the Grading Committee are pressing state boards to further action.

Dr. Burgess' announcement that she would not again appear before a biennial convention as Director of the Study of the Grading Committee was a useful reminder that that exceedingly important study will end at the close of next year. Miss Goodrich's vivid discussion of her paper, which revived a tired audience in an extraordinary fashion, by implication pointed out that there is no over-supply of good nurses, although Dr. Burgess' unassailable figures point out a serious over-supply of poorly qualified persons. The line of nurses waiting outside the office of the Joint Vocational Service was a visual demonstration of the hunger of nurses for guidance and advice.

Late-afternoon "conferences" had packed audiences just as had the more formal programs given earlier in the day. As always, onlookers were amazed at the devotion of nurses to their calling and their readiness to spend both days and evenings in gathering further information.

Milwaukee was the scene of many reunions. Breakfasts, luncheons and dinners for state and alumnae groups filled the interstices of busy days. The exceedingly beautiful oval ballroom of the Eagles Club was the scene of the brilliant reception given by the Wisconsin nurses for their guests.

Although no two of the five thousand or more who attended carry away identical impressions, the values of such exchange of opinion are far-reaching. The Texas nurses won from Tennessee the friendly struggle for the next convention, and enthusiastically we left Milwaukee, planning to meet again in San Antonio in 1932.

Permanent Values

A BIENNIAL is a costly thing. It involves the expenditure of much precious off-duty time and of funds on the part of the entertaining state. It involves months of planning and of time-consuming work on the part of national headquarters. It involves the cost of time and travel to the individual nurse. What is gained by all this expenditure of time and money? It all depends on the individual. We have heard of principals of schools who call together in successive groups the faculty and student bodies in order to share quickly the experience. We have also heard of principals whose students know only that "the director has been away at some kind of a meeting." We have heard delegates give clear-cut, thoughtful reports of important papers and discussions. We have also heard delegates tell only of the good times they had. If you attended the Biennial, with whom are you sharing your experience? Have you chosen to report those things which will give constructive help?

Department of Nursing Education

EDITED FOR THE NATIONAL LEAGUE OF NURSING EDUCATION BY NINA D. GAGE, M.A., R.N.

Developing Potential Leaders[1]

ELIZABETH C. BURGESS, R.N.

EACH year our programs reflect the problems which confront us, and while the National League of Nursing Education program deals principally with matters closely related to the needs of the students in our schools and with administrative, teaching, and supervisory methods, we are greatly affected by the needs of our profession as a whole, and by the specialized work of our graduates in the field. The fact that the undergraduate school of nursing furnishes the basic preparation, and the graduate school the preparation for specialization in the field, brings those who are concerned with the conduct of these schools very close to all problems in the field of nursing.

Some of the problems we shall discuss were problems many years ago, but many of them are either new or [illegible] at least for the first time; for with increasing demands upon the [illegible] nursing, and with our own [illegible] of what our schools [illegible] and of our obligations to [illegible] our problems increase. [illegible], many of us will be [illegible] of problems as the re[illegible] and analysis study of [illegible] Committee reach us. [illegible] which is a gathering together of facts furnished by the schools themselves, gives us the opportunity of making comparisons for ourselves, and not only furnishes the individual school with illuminating data, but brings to light certain general facts about our schools. Nurses, individually and through their organizations, have contributed generously to make this study possible, threby showing their desire to face facts in an effort aimed at improving the teaching of nursing and through this the nursing care rendered to their patients.

Probably it was a surprise to our friends in general education, perhaps a surprise as well to the boards of trustees of our hospitals, to learn through the pages of the May issue of the *American Journal of Nursing* of the large turnover in the position of superintendent of nurses, as revealed by this study.

What do we think about it ourselves? It perhaps is not as great a surprise to us, for we have previously had presented to us facts concerning this turnover. Ten years ago, the statement was made to this organization that in one state (New York) 60 of the 144 registered schools of nursing had changed superintendents at least once during the year 1919. Now we are told that in four sections of the country the typical student nurse is in her school longer than the superintendent of nurses. We are told that the range of the length of stay of a superintendent of nurses in our schools is from twenty-four months to forty-six months, and, for the country as a whole, half the superintendents of nurses have held their positions thirty-six months or less, and one-fourth have held their positions fifteen months or less.

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[1] [illegible] at the opening session [illegible] Convention of the [illegible] Nursing Education, [illegible] June 6, 1929.

Two reasons are given for this condition:

1. That conditions of employment are not satisfactory; and,
2. That there are as yet few institutions which offer advanced courses in educational and institutional administration which fit women for the position of superintendent of nurses and principal of the school of nursing.

Without doubt, it is frequently shown that conditions of employment are unsatisfactory, and it is likewise true that there is a shortage of persons prepared for educational and administrative posts.

We should probably agree to the changes as listed in this article which are needed to bring about better conditions. Briefly they are:

1. An understanding of the needs of the school on the part of the hospital trustees, and I may add, on the part of the hospital superintendent.
2. Better organization of the school.
3. A demand on the part of hospitals for qualified women.
4. Greater authority, better status and more assistance for the superintendent of nurses and principal of the school on whom rests so great responsibility.
5. Recognition that in acceptance of positions nurses should carefully weigh the ethical considerations involved.

This whole matter appears to me to be one of the most fundamental, if not *the* most fundamental in our whole educational plan. Lack of qualified personnel strikes at the heart of our problem. It is a problem which we have inherited, which has been forced upon us, and which with the rapid growth of schools of nursing in the early years was inevitable. How could the little group of early schools produce, in any number, women qualified to undertake the carrying on of the rapidly growing number of schools demanded by the hospitals!

True, it was done remarkably well, and we look back upon many of those early schools with admiration, for they drew to them women of experience and culture who, despite their lack of preparation, went out to organize and successfully carry on other schools. It was, however, impossible to keep up with the demand and as the less prepared persons began to head our schools, the inevitable happened and less well-prepared women were admitted and later graduated. Today, it is no unusual thing to have placed in charge of a school of nursing a young woman whose general education has been very limited, who has been graduated from a school of nursing with very limited opportunities, and who is placed in this position of responsibility within so brief a period after her own graduation that she has no appreciation of what she is undertaking.

This is happening in every section of the country. Hospitals seeking qualified heads for their schools are having difficulty in finding qualified persons. Hospitals which seek merely someone with a nurse's training, and with a little executive ability thrown in, seem always to be able to secure some individual willing to undertake what would be to the well prepared woman an impossible task. A large turnover results. Our poor schools are perpetuated, and they will continue to be conducted so long as preparation and qualifications fail to enter into the requirements for positions of importance in hospitals and schools of nursing.

In 1927 the Education Committee

of the League started to study the question of the nursing school personnel. In this study have been included all the members of the educational staff of the school—the superintendent of nurses both in her capacity of superintendent of a nursing service and as principal of the school, the assistant superintendent, the night superintendent, supervisors, instructors and head nurses—all who had educational relation to the student. Many phases of the problem are involved in a study of this type, but undoubtedly the most important phase is determining how to train persons most effectively for the various positions which must be filled. The committee has naturally assumed that they *must* be trained or prepared and it has been and is continuing to seek an answer as to the best methods for such preparation.

One of the first conclusions reached by this committee was that we must follow in the steps of other organisations, both business and professional, and do much training on the job.

Nurses have always been considered a very practical group. We work with our hands as well as with our heads, and from experience we know that the ability to run a ward, to conduct an educational program for students on a ward, to supervise properly a nursing service, and to conduct a school of nursing in a hospital cannot be learned wholly from books. To be sure a woman may acquire a knowledge of teaching methods, of principles of administration, of ethics and of sociology by college work. This knowledge becomes of fundamental importance as a basis for training, but as those who drive automobiles well know, the only way to learn to drive in traffic is to drive in traffic, and so here I want to emphasize especially for the consideration of those who are looking forward to heading schools of nursing that experience *must* be gotten in meeting the problems of the school and hospital before one is ready to assume the position of superintendent of nurses. Persons of experience would never attempt some of the impossible positions which are offered to and accepted by the inexperienced.

The heads of our schools of nursing must be essentially teachers. These teachers while needing what books can give, need to rise through an educational experience. The schools of the country must seek out and advance in their own organisations the able young women on their staffs, and they must be willing to send these young people *out* of their organisations to fill positions in other schools which need them. More than this, schools must be willing to take on their staffs nurses whose basic nursing education has been secured elsewhere. It is essential that the qualified women be given opportunity.

The good schools of nursing in the country should be the training ground for an increasing number of women who will eventually head our schools of nursing.

Dr. George Strayer in writing some years ago on the subject of "Creative Administration" stated that

> Possibly the most severe test that we can put upon the work of the administrator is to ask in what degree these superior persons (referring to those associated with him) have realized their highest possibilities under his leadership.

We must realise that the staff education programs now functioning in many of our schools must aim, not only at improving the quality of the students graduated, but also at increasing the capacity and the knowledge of the nursing staff for meeting the problems of the school and hospital, at preparing that staff for increasing responsibility, and at pushing forward young women of exceptional ability.

We must let other people know about these young women and be willing to spare them from our organizations when they are ready for the advancement which our own institutions cannot offer.

Let us create loan funds and scholarship funds, promote institutes, summer sessions, and regular college courses, and at the same time encourage and promote within our own organizations. Let us share the problems of our schools with our staffs. Our staffs have a right to know the problems, and thus will be in a better position to meet their own later, they will have more courage and greater staying qualities.

Dr. [illegible] in the article above referred to also says:

> Great leadership is dependent upon professional scholarship, professional insight and professional imagination, and these are granted only to one who values the cause he serves above everything else in the world.

This is a great deal to ask, but it is because nursing education has been served by such leaders that really remarkable progress has been made. Our present job, it appears to me, is to seek out, to encourage and assist the young women who are potential leaders.

Some Extracts from the Presidential Address[1]

ANNE L. HANSEN, R.N.

ONE of the most significant studies made during the last two years (and perhaps in all the history of the N. O. P. H. N.) is that made under the leadership of a special committee called the Committee on Policies and Program with Mary S. Gardner as chairman. In the life of an organization there comes a time when it is necessary to view thoughtfully and dispassionately the past and the present, to draw a new map for future activities. Your Board of Directors has gone through such a process on your behalf and now presents to you the results of its deliberations. The statements I give you are for the most part verbatim quotations of the report of the Special Committee approved and adopted by the Board of Directors together with the Director and staff of the organization.

> The Committee desires to state first of all its unqualified belief in the need for a permanent body such as the National Organization for Public Health Nursing, which shall be con- [illegible] public [illegible] health [illegible]
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> [illegible]

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[1] [illegible]

[illegible] Board of Directors believes that the National League of Nursing Education should be looked upon as the nursing educational group. It is believed that eventually most of the educational activities now carried on by the N. O. P. H. N. relative to the education of nurses for the public health field can be allocated to the National League of Nursing Education. This would necessarily be a very gradual process with at all times a close [illegible] to the N. O. P. H. N. and to a considerable extent depending upon the development of the National League itself. Educational programs for public health staff nurses should necessarily remain with the N.O.P.H.N., while those for student nurse affiliations and postgraduate courses in public health nursing might become a League function. A suggested method of the division of responsibility might be for the National League of Nursing Education to take over the present Educational Committee for the N. O. P. H. N. which could then function as the League Committee on Public Health Nursing. To do this, it might be necessary for a time for the N. O. P. H. N. to finance the work of the Committee as at present. Already a similar effort to develop a division of responsibility is being worked out between the *American Journal of Nursing* and the *Public Health Nurse* magazine.

Affiliations for Nursing Schools

From the Viewpoint of the Receiving Hospital

MARIAN ROTTMAN, R.N.

THE rapidity with which affiliating courses for nursing schools [illegible] increased in the last decade would seem to indicate some progress in the development of standards of nursing education. In the State of New York, where there is a total of [illegible] schools of nursing, 110 affiliate for one or more courses. These courses range from one month for [illegible] to twelve months for [illegible] nursing course. The [illegible] at Bellevue has been [illegible] affiliating courses, starting [illegible] or earlier. Annie W. [illegible] General Director, expressed [illegible] a program to [illegible] of students from a [illegible] with a variety of [illegible]

[illegible] affiliations, this presentation will be from the point of view of the receiving school. In offering affiliations it is customary to enter into contract with the different schools, and for that reason we will begin the discussion there.

A contract is nothing more nor less than an agreement between two schools, and should be so considered in this connection. The affiliating school agrees to send a certain number of students for affiliating courses at definite and stated intervals. In the agreement it is specified that these must have completed certain fundamental courses in the home school before entering upon the affiliation. Division of services, the amount of classwork to be given, maintenance, care when ill, travel expenses, discipline, and exchange of records should all be agreed upon. The length of time required to complete the contract must also be stated. This is very necessary for the protection of both the students in affiliation and the nursing service in the receiving hospital.

There should be no justification for either school or hospital to fail to live up to the terms of the contract. And here I might say difficulties sometimes do arise. A conference between principals is all that is usually necessary, if enough notice is given, when it appears that it will be impossible to abide by the terms of the contract. I refer here to the failure of affiliating schools to send their full quota of students or the necessity of increasing the number. At least three months' notification is necessary to make adjustments to meet these requests. Failure to live up to the terms of the contract by either school would justify its abrogation.

The division of services and the amount of instruction, at least the minimum, is determined by the State Department of Education through the Division of Nursing Education. Maintenance, as well as care when ill, is usually given by the receiving school. Here there are frequent problems which will be discussed under health requirements. Travel expenses are cared for by the home school. The exchange of records requires more than mere mention and will be taken up as a single topic.

Instruction

No school should accept affiliating students unless there is enough clinical material available for instruction for the number of nurses assigned to the service. To lessen the opportunity for education of the regular nursing students in favor of the affiliating students is unfair, and should be prohibited by the State Department or the Nurses' Examining Board. There should also be adequate supervision for the number of students accepted. In all courses for which affiliating students are accepted, the classwork and service should be correlated. If instruction is given during practice periods, not only the education of the student is enhanced, but the nursing care of the patient is far more intelligent and effective. This can be done through the block system. Certain fundamental courses must be completed in the home school before affiliation takes place. This, of course, depends on the services in which affiliation is given. For courses in pediatrics and medicine, which are perhaps the most common, the students should have completed their operating-room duty. In addition to their basic sciences they should have completed materia medica, dietotherapy and pathology. It may seem superfluous to mention this, but it has to be checked very closely. When the affiliation is for communicable-disease nursing the student should have completed operating-room duty and pediatrics. If the affiliation is for public health nursing with a visiting nurse association, the student's experience should have included not only medical and surgical nursing but, in addition, operating room, diet kitchen, pediatrics, obstetrics and communicable-disease nursing. This not only ensures more effective care to district patients, and less worry and responsibility for the district supervisor, but the student is better educated by reason of this background of experience which cannot be compared with that acquired by students less well prepared.

The long term affiliation, covering a year of general nursing, should have as a prerequisite not only the basic preliminary course, but [illegible] [illegible]ing, the theory of diet in disease, and [illegible] as well. The services for [illegible] are in affiliation should [illegible] lectures, nursing classes and [illegible] closely correlated with the [illegible] care of the patients of that [illegible]. Since all of these students [illegible] the principles and practice [illegible] in their home schools, one [illegible] see what the problem [illegible] in regard to methods and [illegible]. How then is it possible to [illegible] uniformity in ward and nursing [illegible] and procedures, when students from a number of different schools are distributed throughout the nursing service of a hospital? This was the situation which confronted the nursing school at Bellevue.

In this school which averages a turnover of 250 affiliating students during the year, there are long-term and short-term affiliations. The long [illegible] twelve months in a general [illegible], the short term, a six months' period divided between two nursing services.

In an attempt to solve the problem, in the spring of 1926, it was decided to hold an institute for directors of long-term affiliating schools and their instructors in nursing practice. Every school accepted the invitation and sent its representatives. Standards of [illegible] and uniformity of methods were [illegible] and procedures were [illegible]. Following this the [illegible] adopted the Bellevue technic [illegible]. This was the first step [illegible] the problems facing [illegible] and supervisors in their [illegible] ward teaching and supervision. The students coming for [illegible] affiliations, those of six [illegible] given a short intensive [illegible] nursing procedures [illegible] upon entering the school. [illegible], a fair degree of [illegible] method became possible [illegible] of common procedure from which instruction can proceed.

If students enter for a service shorter in time than the course of the regular students, a proportionate number of hours of classwork is given, always covering, however, the minimum number of hours required by the State for that subject.

Health Requirements

It is gratifying to find year by year improvement in the health education programs of affiliating schools. There is still, however, much to be desired. I have heard directors of large schools offering affiliations say that the affiliating student presents a very great administrative problem. In our largest affiliating school the loss of time by this group of students is two to one as compared with the regular students of the school. What is the reason for it? It would appear that first of all there is not a careful selection on the basis of physical fitness. There is not the early reporting of symptoms that there should be, so that instead of preventing absence from duty by early treatment of symptoms, the student stays on duty without reporting until she is no longer able to do so, thus exposing her patients and her co-workers to all sorts of acute infections. At the end of six months or a year, when she has learned to coöperate in the health program, she returns to the home school, is replaced by another with whom we have practically the same experience. There is also another group of students who are off duty a large portion of their time. This group appears to be uninterested and finds it easier to be in the infirmary than on duty. When the exchange date comes, these students either have to remain to complete their duties and classwork, or they must return if more than the regular allowance of sick time is lost. Both groups are problems. I do not mean to say that every affiliating student is included in these two groups. Fortunately there are many who do cooperate, but the number could be larger.

Within the last year the home school has been asked to appoint a group leader who acts as a liaison officer between the two schools. This has been very successful from the point of view of the receiving school. In all cases of minor illness where a student is off duty for a day or two, the home school principal is kept informed through the group leader. In cases of severe illness or emergency operations, the home school is informed through the Health Service. In order to reduce the amount of time lost through illness the affiliating schools are notified of conditions which will eliminate students from the affiliation. These include thyroid conditions, flat feet, hypertrophied tonsils with symptoms—history of previous attacks of rheumatism, major heart lesions of any kind, and frequent headaches.

Social and Recreational Activities

ALL students, be they affiliating or regular, should have the same privileges in the home and social life of the school, unless this is not permitted by the home school. Frequently, by request of the home school, affiliating students are not granted the overnight leave. In all instances the responsibility for this permission is assumed by the parents or legal guardian. Other privileges extend to hours off duty, late leaves, attendance at school parties, membership in the Students' Association and in athletic clubs. As associate members they pay dues, but are not eligible for office. The same rules and regulations apply to all living in the students' home, and occasionally we find a tendency to disregard them. In students where this has occurred there seems to be a lack of the proper attitude towards rules and regulation and authority. The only reason for regulation is the welfare of the student both physically and morally. Frequently affiliating students are not interested in participating in school activities. This may be due to strangeness at first. From observation it seems, in some instances, to be a lack of interest in maintaining professional standing or of knowledge or appreciation of the ideals of the profession.

Discipline

SINCE the same privileges of membership in all student activities and home life are extended to the affiliating student, at least some of the responsibilities are hers. Respect for the profession in general and the receiving school in particular should be expected. At times a single act of one student on the ward or on the street may bring criticism and reflection on all the students in the school, for the patients, visitors and their friends do not always understand the intricacies of administration and to them a nurse is a nurse, and reflects either credit or discredit on the hospital with which she is connected. She should always guard the reputation of the profession and the school where her [illegible] for [illegible] trial or that privilege may be denied her. The receiving school has [illegible] to dismiss her; that is the prerogative alone of the home school. I have known directors of schools who have dismissed students returned for disciplinary reasons. This I do not believe is fair. Dismissal should depend on the nature and seriousness of [illegible]. Minor discipline, such as loss of late leaves, etc., is administered to all students by the Head of [illegible].

Efficiency Ratings

HERE again there is apt to be misunderstanding if the efficiency report is not thoroughly understood. One could wish that there might be some degree of uniformity in the system of marking in nursing schools. The letter "C," which means average, may have a numerical value anywhere from [illegible] per cent to 85 per cent. Since "C" is average, it should stand half way between failure and the highest grade, and since 50 per cent of all [illegible] are supposed to be average it [illegible] to be a fairly good grade. [illegible] in schools of nursing the [illegible] are graded as "A" and "B" where "C" would be more indicative of [illegible]. For this reason many [illegible] receiving "C" will protest [illegible] "A" or "B" plus has [illegible] the record in the home [illegible] these same students are [illegible] with their co-[illegible] distribution curve, we [illegible] "C," and perhaps the [illegible]. In all of the schools [illegible] of Hospitals of [illegible] have adopted 83 per [illegible] numerical value of "C," [illegible] "D" as passing. [illegible] the student to [illegible] and the affiliating [illegible] usually say, "My supervisor [illegible] understand." For this reason the home school is informed of our grading schedule.

In grading the students we have tried to develop two reports. One, the student sees and signs after a conference with the head nurse and supervisor. She then knows why she has received the grades given, and if there is objection on her part the supervisor can relate specific instances of poor work from her "rounds record." It is an efficiency record of her technical and professional skill. The other, still in the process of consideration, gives a confidential report concerning feelings and intangible somethings which those directing and supervising the student become aware of. How many of us have heard a head nurse or supervisor say: "I have a feeling about that student that I can't define; I don't trust her." Certainly, nursing as a profession should be guarded as carefully as law or medicine, and if a student radiates that impression to a head nurse or supervisor or a group of them, some attention should be given to it. One cannot expect the head nurse to put this on the report to be seen by the student, but a confidential report should give an opportunity to clear the student or eliminate her if tangible evidence can be secured. The confidential report is strictly what its name implies and gives us an idea of the student not so much as a nurse, but as a woman.

Records

A PRE-AFFILIATING record of the amount of classwork covered, the services completed and the student's standing in the home school should be sent to the receiving school. A complete physical examination of the student as she enters upon affiliation should accompany her records. All prophylactic sera and tests should be completed before affiliation, unless there is a good reason for not doing so, and such reason should be stated in the health record. I believe it would be helpful if a student's health attitude could be stated. It would thus be possible to follow more carefully those students whose attitude on health needs help. In order to hold the student up to her capabilities, her rank in her own school should be stated.

Upon completion of the course, records should be returned to the home school as early as possible. These should be as complete as those required upon application. A copy of the record of services, classwork, efficiency and any other statement which might be valuable as future reference should be filed at the receiving school in addition to those sent to the home school. Usually application for membership in the American Red Cross or for college entrance will require a statement from the receiving school with a transcript of the record.

In closing, I want to express an appreciation of the very fine attitude of the majority of students affiliating with our schools. As a rule the students come to the office of the school to thank the staff for the courtesy and opportunities which have been extended to them. Occasionally the attitude of a superintendent of nurses is reflected in her students, when she feels that the affiliation is maintained only because the State Department of Education requires it, not because the students derive any benefit from it. Those students are rare, but easy to identify by the quality of their work.

Sending Students for Affiliation[1]

Problems and Responsibilities of Home Schools

CARRIE M. HALL, R.N.

AFFILIATIONS seem to me to be both a joy and a sorrow. I say this because of the well known dual responsibility which rests on most directors of schools of nursing. From the angle of the principal of a school of nursing, the opportunities for affiliations are an unquestioned blessing. From the point of view of the superintendent of nurses, who is responsible for the nursing care of the sick, the necessity for sending students continually for affiliation is a tremendous problem. It is obvious, I think, that affiliations should be planned with a definite educational purpose in view.

They appear to me to be of two kinds—first for teaching and experience in basic subjects, essential for ensuring the school a place on the registered or approved lists and enabling the graduates of the school to become registered nurses; second, supplementary or elective affiliations in those branches of nursing which it is desirable to give to students, such as psychiatric nursing, public health nursing, communicable disease nursing, and nursing of diseases of eye, ear, nose, and throat.

I assume that the problems are similar in most schools. I can only tell my personal experience. My school averages [illegible] students and is connected with a hospital which gives experience in only two of the four basic subjects, medical and surgical nursing. We, therefore, must affiliate for obstetrics and pediatrics. Forty students are sent yearly for three months each for each of these services. In other words, every student must be absent for a period of six months for affiliations in basic subjects.

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[1] Read at the General Session on Affiliations, Milwaukee, June 12, 1930.

Added to this we offer three so-called elective affiliations: one of four months in public health nursing; one of two months in nursing of eye, ear, nose, and throat cases; one of three months in nursing of mental diseases. Students may signify their preferences for these opportunities and they are granted if their records warrant and if the quotas allow.

Most of our affiliations occur in the third year. We begin to send students during the last quarter of the second year. Not all students follow the same path. Some have obstetrics before pediatrics and others have pediatrics before obstetrics; some have eye and ear affiliation before either; some, after. One group of students on public health affiliation has both pediatrics and obstetrics before affiliation; the other has only obstetrics.

In the case of the two basic affiliations, the affiliations for nursing diseases of eye, ear, nose, and throat cases, and in psychiatric nursing, the students receive full maintenance, in addition to teaching and experience in these subjects. In the case of affiliations for public health nursing at Simmons College, the hospital pays the tuition fees of $30 for each student and maintains her during the four-month period at a cost which is estimated roughly at $166, making a total cost to the hospital, per student, of approximately $196. The number of students who may be sent in any one year is limited, by vote of the board of trustees, to twelve.

The two basic courses, pediatrics and obstetrics, require that students shall be sent all the year. The eye and ear affiliation of two months offers affiliations the year around. Public health nursing, a field work of four months with classes and conferences at Simmons College, is given twice a year, leaving four summer months free from this work. The affiliation which we have made for psychiatric nursing of three months is offered only twice in the year—October to December inclusive, and February to April inclusive.

For the past three years we have sent students annually as follows:

	Students
Field work in public health nursing..	12
Nursing of diseases of eye, ear, nose, and throat....................	13
Psychiatric nursing................	4
Total........................	29

As an average of thirty-eight students graduates yearly, it will be seen that 75 per cent of each senior class is given an elective affiliation. For these twenty-nine affiliations the average length of time is three months each, therefore, 100 per cent of senior students are away on affiliated duty for six months and 75 per cent of senior students are absent three months in addition. Or an average of twenty-eight senior students are always on duty in some institution other than the home hospital. Added to this there are two entering classes a year with preliminary courses of four months, so that eight months of the year, twenty to thirty-six students are not on duty in wards or other departments. The other four months of the year are vacation months when allowance must always be made for having from twenty to twenty-eight students absent constantly on vacations. Deduct the students in the preliminary course, students away on vacations, and the numbers on affiliations, from the total census of the school and the result is that at all times of the year there are 40 per cent of the students who are not available for the care of the sick in the hospital. Counting the absences for affiliations and the students in the preliminary course, only, we find that the school is larger by about 30 per cent in the interests of giving education to its students than it would need to be to supply nursing care to the patients in the hospital.

This will show, what you probably already know, that maintaining a large number of affiliations requires a much larger school than is necessary to nurse the sick in the hospital. The more affiliations there are, the larger the school must be unless it is fortunate in having a graduate floor-duty staff. The greater the size of the school becomes, the greater the numbers must be who are sent yearly for these affiliations. It is a vicious circle, or a constantly increasing pyramid. It is not difficult to understand what this does to the housing and maintenance problems of a hospital. If trustees fully understood this situation, it would appear that they could not be so sure that maintaining a training school offers the cheapest means of nursing the sick in the hospital. I marvel at those hospitals which seem to find economy in sending students hundreds of miles for essential affiliations.

It is the responsibility of the school sending students to select affiliating agencies with care. In an effort to give a broader education and a glimpse of more fields of nursing it is quite possible to exploit students shamefully.

The director of the school sending students should know before entering into such contracts, what are the living conditions, hours of duty, facilities for teaching, quality of instructors and lecturers, clinical facilities, and whether the institution or organization is receiving such students merely to supplement the working staff or whether genuine experience is being offered and supervised in a way to make it of true educational value.

Schools sending students for affiliations should be responsible for careful selection of students, and I believe should maintain substantially the same standards of educational preparation for admission as the schools which they are asking to receive their students. There are many valuable features for the students other than their actual education. They make contacts with students from other schools and acquire an understanding of nursing and the common problems of all schools in a way that they never could do in their own schools. They make friends in these other schools who often come to be of genuine assistance in their later graduate work. It is, therefore, particularly desirable that the affiliation meeting-ground should accept only students from schools in which the essential requirements of previous education, preliminary course, hours of duty, etc., are of uniform standards.

Schools should see to it that all students going for these affiliations have successfully completed the subjects in the preliminary course and have been followed by a period of ward [illegible] that they have at least average ability and are reasonably well adapted to [illegible] nursing. They should also have had courses in [illegible], [illegible] and therapeutics, [illegible], [illegible], and at least [illegible] experience in general medical and surgical nursing. For [illegible] [illegible] it is highly desirable, and sometimes [illegible] that students shall previously have had training and experience in operating-room [illegible].

Schools sending students should [illegible] considerable effort to send their students in as good physical condition as possible. It is undesirable to assign [illegible] to a definite affiliation period in a new environment at the end of a hard year of work when they may be thoroughly tired. It is very helpful if a student be given her annual vacation just before being sent for a term of affiliated duty. Quite definite arrangements should be adopted at the start for determining responsibility for the care of students who become ill while away on affiliation.

One of the interesting features of the affiliation program comes from studying the individual reports as submitted by the affiliated schools. We usually assure our students that they are entering this new work with clean slates and that no advance reports of a prejudicial nature have been sent. It is surprising to find in how many instances the reports summarize justly and well our own estimates of students' abilities. It is also necessary to scrutinize reports from time to time to make sure that the students continue to receive the particular teaching and experiences for which they are being sent, also those which are required by the state boards.

These heavy affiliation programs make the senior year a very difficult one in the matter of the third year class and lecture work in the home school. If the affiliating schools are geographically near each other, it is frequently possible to bring students back three or four hours a week for this work. If they are geographically widely separated the difficulties are much greater. In any event, one has to grant that the work of the affiliated course is the most important and must take first place. If there is an exchange affiliation the problem offers much in the way of reciprocal arrangements. Both the school sending and the school receiving students should expect to alter contracts and terminate relationship only after due notice has been given and accepted.

I imagine that directors of schools in which all the basic subjects are provided, and some of the desirable ones as well, do not realize the difficult problems which they are spared. It is true that they must make assignments for these same duties within their own walls, but I would think such arrangements would admit of great flexibility. The affiliation program requires that definite obligations must be met at stated periods and many events may occur to make this difficult.

On the whole I think I may say that our relationships with affiliated schools have been cordial and happy.

Objective Methods in Classroom Tests[1]

T. L. TORGERSON

EXAMINATIONS are looked upon by most college students as a necessary evil, as the favorite indoor sport of college professors, and as a disturbing factor to their general peace of mind. To the average college faculty, a stack of blue books is just another reminder that the zero hour has again arrived when the desk must be cleared and the blue pencil brought into action. In common with other college traditions, examinations have been handed down to us from the distant past, and to question their validity or present usefulness would be highly unconventional if not sacrilegious.

Examinations as such are not new. On the contrary, they are as old as formal education itself. The Greeks, the Romans and the Chinese employed elaborate examination schemes centuries ago. Public examinations played a prominent part in education during the Middle Ages. These examinations prior to the nineteenth century were largely oral. In 1845 Horace Mann vigorously set forth the advantages of the written or the "new" examination over the oral, especially pointing out its advantages from the standpoint of uniformity, that is, the fact that the same examination could be given to all pupils in a class.

Education has made pronounced strides during the past half-century. Consider any phase you choose, curriculum, textbooks, methods, equipment, buildings, etc., and note the remarkable changes that have taken place. With this advance in education has the technic of examinations shown the same progress? Do not the following questions run true to the form of questions used in our essay or traditional examinations of today?

For what were the Egyptians distinguished?
Give an account of the feudal system.
What do you understand by an embargo?

These questions are identical or parallel to the typical questions of the essay type of examination of the present time, yet they were selected from an examination given in the city of Boston in 1845. The fact remains that we are still asking the students to compare, define, describe, discuss and explain in their examinations today as we did a century ago. The content of the courses has changed, methods of instruction have improved, but the examination questions are of the same type and the same primitive subjective methods of grading prevail.

While we frequently question the old, the mere fact that it is old is in itself no criterion of its lack of worth. One must consider the results of experimentation as to the merits and demerits of the traditional examination.

During the past ten or more years, largely as a result of the studies made of the traditional examination, there has developed a new and objective examination employing the technic used in the standardized test. This new examination has won favor and has been widely accepted in the elementary and secondary schools of the country, but has not been taken seriously by college teachers outside of departments of education and psychology, and to some extent in the modern languages.

Time will not permit a review of the many studies that have been made with regard to the effectiveness of the essay or traditional examinations. I shall briefly summarise the results of one of the first investigations which, perhaps, has attracted more attention than any other single study dealing with this subject.

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[1] Read at the Instructors' Section, National League of Nursing Education, June 12.

In 1912, Professor Starch of the University of Wisconsin conducted a careful investigation among a group of teachers from high schools of the North Central Association. A photographic reproduction was made of examination papers, written by a student in English, Geometry, and History at the end of the first year in high school. The papers were marked by 142 English teachers, 115 mathematics teachers, and 70 history teachers. All papers were marked on a percentage basis of 100. Some startling results were found. The marks on the English paper ranged from 60 to 98, on the history paper from 40 to 90, and on the geometry paper from 28 to 92. Similar studies have been made since that time, and with the same results. The writer has conducted such an experiment a number of times in his classes in measurements composed of experienced teachers by placing in their hands a copy of an arithmetic examination consisting of ten problems of about the seventh grade level. The results have been practically the same in every instance, the marks ranging from 40 to 90. The experiments during the past ten years all confirm the conclusion that there is a wide disagreement between the marks given to the same examination paper by different examiners and between the marks given to the same paper at different times by the same examiner. The following interesting experiment is reported by Wood of Columbia in the grading of history papers by a group of college professors of history in the summer of 1921. One of the five or six expert readers assigned to a certain group of history papers, after scoring a few, wrote out for his own convenience what he considered a model paper for the given set of ten questions. By some mischance, this model fell into the hands of another reader who graded it in perfectly *bona fide* fashion. The mark he assigned to it was below passing and, in accordance with the custom, this model was rated by a number of other expert readers in order to ensure that it was properly marked. The marks assigned to it by these readers varied from 40 to 90.

Examinations may be classified under two general headings, written and oral. The written examination may further be classified as traditional, objective, and standardised. This paper will be limited to a discussion of the traditional and the objective types.

What are the purposes or functions of examinations? It is generally agreed that examinations are instruments of motivation and measurement. Training in written expression has also been proposed as a legitimate function of the examination. Training in written expression, however, as a function of the examination cannot be considered seriously. At best, the examination period can only hope to provide an inadequate measure of, and not training in, written expression. Opportunity is afforded in every school for definite training directly in this field.

Observation and experimental study have shown that examinations serve to motivate pupils to make more careful daily preparation, and to organise the course material into related units for proper assimilation and later recall. Over-learning is a valuable means of ensuring the retention of material to be learned beyond immediate need. The examination has proven to be a useful stimulus to secure a greater amount of overlearning.

While we have no experimental evidence, it is probably true that the type of examination that motivates most is the examination that is most interesting to the student and impresses him as being fair.

Measurement as a function of the examination is of paramount importance. On the college level we measure in order that we may diagnose student difficulties, diagnose weaknesses in teaching, [illegible] or both for promotion. Too often we use examinations for the sole purpose of measuring the outcomes of instruction at the end of the semester, as a basis for promotion or grades for the course. [illegible] in order to diagnose student difficulties and in order to diagnose weaknesses in instruction is practically an untouched field on the college level. I am [illegible] that most student learning difficulties are the result of [illegible] teaching. [illegible]

[illegible] methods of instruction and lack of provision for individual differences, and are as applicable to the college level today as they were to the elementary and secondary levels fifteen years ago.

The point that I wish to emphasize is that the most important function of the examination is diagnostic. As a diagnostic instrument it is indispensable in the teaching process. We have learned that it is a mistake, except in a few courses, to assume that all students come to the course with no knowledge of the content of the course. A pretest on a unit of many courses will reveal different degrees of mastery of the new field varying from zero to nearly a perfect mastery. A diagnostic test at the close of the unit will reveal teacher and pupil weaknesses which will serve as the basis for remedial individual and class instruction before attacking the new unit. The instructor who follows a course of pretests before the unit, a period of instruction and teaching of the unit, a diagnostic test covering the unit [illegible], followed by remedial instruction before going to the next, will increase the effectiveness many fold. To the college professor who said, "The college would be a delightful place were it not for the students," these suggestions will, of course, make no appeal.

[illegible] relative [illegible] examination [illegible] examina[illegible] ex[illegible] up [illegible] is [illegible]? [illegible]

[illegible] it is said to be reliable. In other words a good examination is valid and reliable. An examination in one subject has no validity as a measure of the attainment in another subject. An examination that has been prepared by one instructor will not have a high validity if given to a class in the same subject in another institution where the text, lectures, and laboratory exercises are not the same. To ensure a high curricular validity the examination must provide an extensive sampling of the work covered by a particular class. The questions must not be ambiguous and the [illegible] must not be influenced by such extraneous factors as spelling, handwriting, fatigue, etc.

In order to ensure reliability the examination must provide for extensive sampling and subjectivity, or the personal equation of the examiner must be eliminated. This means that the examination must be objective and instead of five to ten questions there must be at least fifty, preferably 100 questions. The reliability of a test is generally expressed in terms of a coefficient of reliability. This coefficient of reliability is found by correlating the scores on two applications of the same or parallel forms of a test given to the same pupils by the same examiner. If the pupils receive the same scores or retain their relative positions in the class on the two applications of the test, the test has a [illegible] coefficient of reliability [illegible]. If there is no relationship between the scores the co-efficient [illegible], and the test has no [illegible] always a [illegible] the more nearly the [illegible] +1.00 the more [illegible]. What standard of [illegible] is expected? An [illegible] of a class as a whole [illegible] by a test with a reliability coefficient of +.70. Class averages, however, are of little practical value; we are concerned with the individuals in the class, and an acceptably accurate measure of the individual pupils requires a reliability coefficient of +.90.

Let us pause for a moment to consider the relative merits of the traditional and the objective examination with regard to reliability.

Ruch has assembled from a number of sources, principally from the writings of Monroe and Wood, and his own researches, a total of 285 reliability coefficients for the traditional examination. These coefficients range from slightly below zero to positive +.97 with a median of +.59. Only twenty-one of the coefficients reached or exceeded +.90. The middle 50 per cent ranged from +.40 to +.75. These data tend to show that the average reliability of the old type traditional examination does not exceed +.60 to +.65. The average reliability of sixteen State Diploma Examinations in social science, in an investigation by Ruch, was about +.59. The average reliability of the New York Regents' examination in the social studies in 1923 and 1924 as investigated by Gordon was approximately +.50. A coefficient of +.50 is thirteen per cent better than a pure guess, while a coefficient of +.60 is but twenty per cent better than a pure guess.

In an investigation by Wood of Columbia on the relative reliabilities of the old and the new type New York Regents' Examinations he found the following results. The reliability of the old type, ninety-minute Regents' Examination in French II was .783; French III, .723; French IV, .415; Spanish II, .722; Spanish III, .700; and Spanish IV, .695. The reliability of the new type objective 90-minute examination in French was .962; Spanish, .965; German, .952 and physics, .962. The highest reliability for the old type was .79 and lowest for the new type was .86. In 1921 Wood found that the College Entrance Board examination in algebra had a reliability of .76 and the examination in geometry a reliability of .61. These examinations are three hours in length. The results of these studies seem to justify the conclusion that the traditional examination may be reliable enough to determine group averages but is too unreliable for individual measurement, while the objective examination will readily yield coefficients above .95 and thus provide reliable measures of individual student performance.

Wood correlated the marks received on the traditional examination and the marks received on an objective examination by the same students over the same content in law courses, with their course marks. The traditional examination correlated with their course marks to the extent of .48, while the objective examination correlated with their course marks to the extent of .72. This tends to give some measure of the validity of the new as compared with the old examination.

Ruch has raised the interesting question of what fraction of a student's knowledge is elicited when a pupil is asked to discuss a certain problem. He attempted to answer this question by giving students an examination of the traditional type consisting of as many essay type questions as were necessary to cover the contents of a chapter. The following day the same classes took an objective test covering every fact of importance in the chapter. On the basis of the results Ruch arrives at the following conclusions:

1. On the average the essay question calls forth less than half of the pupil's knowledge, two-fifths being a closer estimate.
2. The essay examination requires approximately twice as much time as the objective test for a given unit of subject matter, if the unit is treated exhaustively.
3. Since the essay examination requires twice as much time and evokes less than half as much knowledge, the objective test is from four to five times as efficient as a device for sampling.

The writer of this paper does not intend to imply that the essay or traditional type of examination should be abolished and supplanted by the objective type. In its present form it is, however, obsolete and should be discarded. It can be improved, however, and made a very valuable supplement to the objective type. Improvement can be made if we recognize its defects. How to improve the written examination is too long a story to be presented in this paper. The materials you have in your possession may be of some help to you in this problem.

Time will permit only an enumeration of some of the outstanding advantages and disadvantages of the traditional examination and of the objective examination.

Advantages of the Essay or Traditional Examination

1. Useful as a measure of attitudes.
2. Useful in securing a measure of organized and connected discussion.
3. Useful in measuring the student's ability to apply principles.
4. Wide applicability.
5. Guessing is reduced to a minimum.

Disadvantages

1. Low validity because of limited sampling and measurement of irrelevant factors.
2. Low reliability because of subjectivity and limited sampling.
3. Scoring is difficult and time-consuming.
4. Encourages bluffing.
5. Not useful as an instrument of research.

Advantages of the Informal Objective Examination

1. High validity and reliability.
2. Can be made highly diagnostic.
3. Valuable for instructional purposes (pre-testing and diagnostic testing).
4. Prevents bluffing.
5. Interesting to students.

Disadvantages

1. Tendency to become highly factual.
2. Danger of over-emphasizing memory questions.
3. Difficult to prepare.
4. Limited use in some subjects.
5. No chance for student self-expression.

I shall close my discussion by reference to the use of objective tests in higher education as reported in the last two issues of the *Yearbook of the National Society of College Teaching of Education*. In the yearbook for 1929, the committee in charge stated that in response to their questionnaire it appeared that about one fifth of the colleges were engaged in activities centering around the improvement of examinations, involving the adoption of the new type test or the use of the comprehensive examination. In the yearbook for 1930, Pressey of Ohio State states:

> The use of quantitative measurement for making educational diagnosis of the difficulties which students in their college work experience is receiving attention at many institutions of higher learning. The emphasis on the use of such measurement in the field of higher education is relatively new, although the instruments of measurement for this purpose have been used for more than a decade in the field of elementary and secondary education.

On the basis of 100 replies from 318 members of the National Society of College Teachers of Education, Manuel states:

> The essay test is far from being abandoned by members of the National Society of College Teachers of Education. Many mention it specifically, and a few indicate that chief dependence is placed upon it. There is a marked tendency, however, toward preference for the so-called new-type or objective tests, and in some cases these tests are used exclusively.

* * *

The Public Health Nurse for July

Official Magazine of the National Organization for Public Health Nursing

Sophie C. Nelson, President (Illustration).
Impressions of the Convention, Helen Hartley.
Convention Reports.
Administration of a Public Health Service, [illegible], M.D.
Preparation for Health Teaching, Adelbert A. [illegible]
The Nurse's Responsibility for Community [illegible] M. Davis.
[illegible] Ryan, M.D.
[illegible] Nursing Legislation, Pearl [illegible]
The Scope and Aim of a Mental Hygiene Program in a Public Health Nursing Association, Grace L. Anderson.
Mental Health in Boston, Marie Knowles.
Communicable Disease Control, John T. Sippy, M.D.
Hourly Nursing from V.N.A. Viewpoint, Ruth Hubbard.
Vital Statistics, T. F. Murphy, M.D.
Relation of the Rural Nurse to the Social Work Program, Eleanor W. Mumford.

Department of Red Cross Nursing

DEPARTMENT EDITOR: CLARA D. NOYES, DIRECTOR, NURSING SERVICE, AMERICAN RED CROSS

The Great Red Cross Convention

FROM May fifth to eighth, inclusive, the annual convention of the American Red Cross brought together many hundreds of chapter delegates, as well as guests at National Headquarters in Washington. Among these were over one hundred Red Cross nurses, fourteen of whom were official delegates of state nurses' associations. The others included representatives of state and local committees on Red Cross Nursing Service, chapter public health nurses, instructors in Home Hygiene and Care of the Sick, and guests. Coincident with this convention, the International Mental Hygiene Congress was also in session, consequently many visiting nurses, including a few old friends from foreign countries, were in the city. Unfortunately the weather was very warm, but in spite of this the city was very beautiful in its fresh green garb of springtime. The program of the Red Cross, covering all the activities of the organization, was discussed at plenary sessions, round tables and group conferences. In addition, there were interesting social occasions. There was the usual banquet and a luncheon, at which speakers of national and international prominence appeared.

The main theme of the convention was "The Red Cross in the Home." Like a scarlet thread this idea could be traced through the program in all of its aspects. The Junior Red Cross, with its two hundred high school delegates, made a bright spot of youth and enthusiasm in the affairs of the Association. From the address by Constance Payne, the Junior Red Cross delegate from Terre Haute, Indiana, we quote the following paragraph:

> We are determined, first of all, there shall be no more war. We have learned, first-hand, the price people pay in money, in lives lost or shattered, and in [illegible] minds or souls, besides we will prevent the causes of war by promoting international friendship. We are chatting over the sea lanes with these friends of ours and have discovered their educational systems, their customs, industries, and their ideals of beauty in art and life. We would deprive ourselves of much joy and happiness if we were anything but friends.

The promotion of this type of thinking through the International School of Correspondence cannot but prove one of the greatest factors toward the development of permanent world peace.

An interesting round table on the problems of the Nursing Service was held in the office of the Director. This was attended by the members of the state and local committees, and also the field representatives. There was also a nurses' luncheon, at which we welcomed over one hundred Red Cross nurses, as well as our old friends from foreign lands—Miss [illegible] from Finland, Miss Gordon from [illegible], and Miss [illegible] from the League of Red Cross Societies.

There were many [illegible] presented by the annual meeting which was one [illegible] the celebration of the golden anniversary of the American Red Cross in 1931 with a nation-wide observance on May 21, the fiftieth birthday of the Society's [illegible]. Another recommended the establishment by the Red Cross of first-aid service on highways in order to prevent the heavy toll in automobile deaths, this service to be under the direction of local chapters.

At the time the great convention was in progress, many disasters, affecting twelve states, were receiving assistance from the American Red Cross. In ninety per cent of the communities affected there were strong Red Cross chapter organisations, and forty-five national relief workers were at the scene of these disasters.

Quite the pleasantest experience of a great national convention is that which comes from the meetings and brief chats with those we know, or with those who hitherto have been names only. While we are inclined to feel that we have reached the point of oversaturation from too many conventions, conferences, state meetings, etc., nevertheless it would be difficult to decide, because of the size of our country and the breadth of our interests, which could be eliminated. We can truthfully say, as far as we are concerned, even after many years of convention attending, that we never leave one without having acquired additional information and deriving therefrom an additional store of enthusiasm and pleasure.

The Passing of S. Lillian Clayton

THE death on May second, in Philadelphia, Pennsylvania, of Miss Clayton, the President of the American Nurses' Association, for many years a member of the Local Committee on Red Cross Nursing Service of Philadelphia, and also a member of the National Committee on Red Cross Nursing Service, threw a shadow of sadness upon the Red Cross convention. Her death is a serious loss to the nursing profession of the United States. For many years she has been a leader in nursing, not only in her school and the state in which she lived, but of the entire country. She early enrolled in the Red Cross Nursing Service and has always been a strong supporter of its ideals and standards. We join with her many friends and associates in expressing our sorrow and grief at her untimely end.

Another Honor Comes to Dr. Anna Hamilton

THE nurses of the United States who have been working so hard to complete the American Nurses' Memorial School will be delighted to learn that the Legion d'Honneur has been conferred upon Dr. Hamilton by the Government of France. This, following so closely upon the gift of 900,000 francs from the same source to the Florence Nightingale School which was organised under her direction, places the stamp of approval of the Government of her country upon her work in establishing a modern system of nurse education in France. All nurses, but particularly those of America, will be grateful that this recognition came during her life and was not held, as is so frequently the case, until the individual has passed beyond the realm of human knowledge. Let us hope that, although in fragile health at the present time, Dr. Hamilton may live for many years to enjoy the hospital, as well as the school, which is rapidly nearing completion in its beautiful environment at Bagatelle.

I. Malinde Havey Succeeds Miss Fox

WE are glad to announce the appointment of Miss Havey, who has for many years directed the Public Health Nursing Service in the Eastern

Area of the American Red Cross, as successor to Elizabeth G. Fox, whose resignation was reported in the April issue of the *Journal*. Miss Havey has had many years of experience in the American Red Cross, beginning as a chapter nurse in Michigan, later as Director of Nursing in the Lake Division of the American Red Cross, and for the last eight years she has been in Washington as Director of the Services in the Eastern Area. Miss Havey thus brings a rich experience in Red Cross activities to her new work as a national director. At present there are over six hundred chapters in the United States engaged in public health nursing, employing about 830 Red Cross public health nurses. While her work in the eastern area has been extensive, for the major portion of the services are located therein, she will now have general direction of those which are in operation in all parts of the United States, as well as in the Philippines and elsewhere.

Enrollments Annulled

THE enrollments of the following American Red Cross nurses have been annulled, but their appointment cards and badges have not been returned. It is to be noted that appointment cards and badges always remain the property of National Headquarters and their return is requested when enrollment is annulled: Lydiamae Dille; Mrs. Earl F. Dingman, *née* Violet C. Durloo; Miss Adelaide Divey; Mrs. Harvey E. Dixon, *née* Mary Conder; Diana Dodds; Nell Winifred Doherty; Mrs. Sadie Janet Dooley, *née* Kerr; Anna Mary Doran; Bridie Mary Doran; Ellen Mary Doran; Alice Dougall; Margaret Elva Douglas; Vivian Dowdell; Mary Ellen Downey; Mrs. Lilla V. Doyle, *née* Murray; Mrs. D. W. Drapeau, *née* Ethel Margaret Bowe; Mrs. Mabel Elizabeth Drew, *née* Kilts; Mrs. Arline E. Dubois, *née* Hall; Bernice Louise Dunton; Mrs. Loretta Eastman; Henrietta Lillian Edholm; Mrs. C. R. Eklund, *née* Anna Christensen; Irene Margaret Ellis; Mrs. Bruce Elston, *née* Agnes Parrish Hamilton; Lenore C. Emmanuele; Mrs. Ollie Emerson, *née* Sara Nicholson; Mrs. George H. Emmons, *née* Agnes Westwater Campbell; Mrs. Gilbert Ensley, *née* Mahala Susan Rice; Blanche Erbaugh; Mrs. Ernest Erdmann, *née* Nelle Baxter Davis; Della Caroline Erickson; Mrs Max Erlich, *née* Amanda Victoria Palmquist; Mrs. W. P. Etling, *née* Frances Marie Hawver, Marguerite Esslinger; Mrs. Claude Evans, *née* Lena B. Sweeney.

Preliminary School for Nurses, University College Hospital, London

THE opening of the New Preliminary Training School for Nurses of the University College Hospital, in April, 1930, says the *British Journal of Nursing*, was an Anglo-American function. The funds were given by the Rockefeller Foundation; both Prince George and Ambassador Dawes took part in the opening exercises; but most important of all it will be recalled that from that hospital came, in 1873, Sister Helen to Bellevue Hospital to be its first superintendent of nurses and a pioneer in modern nursing in this country.

The gift from the Rockefeller Foundation is an educational building. During the exercises Miss R. B. Darbyshire, Matron of the Hospital, presented to Prince George a small figure in silver representing a nurse in the first-year uniform, carrying a book under her arm, setting forth on an eager quest for knowledge. As she gave the statuette to the Prince, Miss Darbyshire said, in part: "This, we hope, is symbolic of the spirit of the nurses who enter our school, and it is our great happiness to know that we can now give our young student nurses the best chance of acquiring that knowledge in a school equipped as an educational building."

The preliminary course is two months and each class is limited to twenty students.

Student Nurses' Page

Learning Prevention First Hand

GERTRUDE SMITH
Fabiola Hospital School of Nursing, Oakland, California

The case study following is one of a series made in an effort to correlate classwork effectively with everyday living. Students themselves are the subjects, and colds, ingrowing toenails and other minor ailments, as well as the rarer and more exciting "appendix," are being studied from the preventive viewpoint.

This study is in no way to be considered either a punishment or a mere effort to protect the hospital pocketbook. The general public has not yet absorbed the idea of prevention. The student is in contact with patients whose illnesses are largely the result of ignorance of preventive measures. Sometimes she sees very little preventive work and, if she does, usually does not apply its principles to herself. Her experience of life is really only beginning and, if we do not help her to correlate classwork on hygiene and prevention with her own and patients' illnesses, she looks upon that classwork as either an impractical dream or as something she visions herself using after graduation, and perhaps even then only if she specializes in public health nursing.

Every teacher who has the imaginative faculty finds out how limited is this faculty in the average human. Our students are average humans and the majority of them are eighteen years of age. Our classwork has its highest value when applied as soon as possible. Its application is essential. Every means should be taken to make it a vital thing in the student's life. This method suggests some success in the objective of teaching health.

E. M. Jamieson, R.N.,
Director, School of Nursing.

Paronychia

Gertrude Smith
October 28, 1929
Student Nurse
Diagnosis—Paronychia of both thumbs

As an introduction to my case study I am giving a quotation taken from the book, *Public Health in the United States*, by H. H. Moore. This quotation was advice given to Cyrus the Great in the sixth century B.C. by his father when the former told him of his provision for medical care of the army.

But these physicians, my son, of whom thou speakest are like menders of torn garments and thus they care for those who have fallen sick. Thy chief anxiety should be to provide for health, for thou oughtest to take care to prevent thy army from falling into sickness at all.

When I became a "torn garment," figuratively speaking, my chief complaint was redness and pain at the base of both thumb nails. The left thumb became reddened and slightly tender about September 18. I reported to the supervisor and the house doctor four days later. On the 24th, the right thumb presented similar symptoms. Other outstanding symptoms beside redness and tenderness were heat and swelling. At the onset of this infection a serous fluid could be expressed from under each cuticle which later developed into a pus-like drainage.

The possible causes of these symptoms were contact with a case of infection, or manicuring with unclean file or orange wood stick. But there were no abrasions, scratches, or pin pricks which would lead one to suspect a possible portal of entry for bacteria. This made it more important that I should have reported it earlier to find the source and prevent a more serious infection but, thinking that it was a minor infection, I treated myself.

This treatment up to the fourth day was hand soaks once a day for two hours in weak lysol solution. After this, for six days, soaks in magnesium sulphate once a day followed by an application of iodine. This reduced the swelling and redness during the day but was followed by recurrence of symptoms at night.

I was accustomed to giving soaks more frequently than this to patients, but it seemed too much trouble to give them to myself even though I know the process of inflammation thoroughly.

On September 30, twelve days after onset, I reported to Dr. S., who examined the thumbs and ordered a wet dressing of hexylresorcinol to be applied.

On October 1, Dr. S. incised both thumbs at the base of the nails under gas anesthesia. I was removed from the treatment room to a private room. No ill effects resulted from the gas anesthesia; but following a hypodermic injection of morphine sulphate, gr. one-sixth, I was dizzy and nauseated, which might indicate an idiosyncrasy for the drug. On October 2, I was awakened with pain in the right thumb extending down the arm. After consulting Dr. M., Dr. S. removed both thumb nails and curetted the underlying tissue, leaving just the tip of the nail for protection of the finger tip. This was done under a general anesthetic. Morphine gr. one-sixth was given hypodermically for pain. Late that afternoon Dr. S. called, and ordered hot compresses for three hours followed by a continued wet dressing of Ochsner's solution to be changed every four hours during the night.

On the morning of October 3 my thumbs were dressed. They showed some improvement, but considerable purulent drainage. The infection seemed localized. The thumbs were soaked for three hours both morning and evening, instead of just two hours once a day as I had done, in hot hexol solution followed by a continuous wet dressing of Ochsner's solution. I was on a general diet and my condition was good.

On October 4, the same treatment was ordered. In the afternoon I was allowed to be up, exposing my thumbs to the direct rays of the sun.

On October 5, Dr. S. dressed my thumbs and dismissed me from the hospital with an order to return to the treatment room both morning and afternoon for hand soaks in weak lysol solution for an hour each time.

On October 6, I was dismissed and returned to my home. The following day Dr. F. dressed the thumbs, but prescribed no additional treatment.

On October 11, the right thumb seemed somewhat painful and reddened. The doctor incised the area and inserted a small rubber drain. The left thumb was clean and a dry dressing was applied.

On October 12, the drain was removed and the wound was free from drainage. Two days later both thumbs were dressed, and Dr. F. dismissed me with both thumbs well on the way to healing.

I returned to the hospital on the 15th. The following morning I reported on duty in the supply room. Vaseline dressings were applied at night and during the day to soften the nails as they grew.

The preventive treatment in this case should have been effective early treatment. The infection would have been checked and I would have saved myself unnecessary suffering and loss of time. Many of us do not know the length of time it takes finger nails to grow and how it feels to be without them while they are growing. It takes several months, sometimes longer, and one has ugly, rough, and rather useless members, meanwhile.

We, as student nurses, do not realise that our lives and our health have economic value, and their evaluation on this basis should render a real service to those who are engaged in their protection as well as to us. We do not realise the loss due to sickness which involves inability to work and increases at the same time the expenses of any individual who is not fortunate enough to be a student nurse. People appreciate the value of health only when they lose it. It is only when they are ill, when earnings stop and expenses rise that they begin to understand. We, as nurses, should be teachers not sufferers, because we are supposed to be leaders in cleanliness, promoters of good hygiene and boosters for the prevention of disease. We must know how great is the value of human life, for human capital is the nation's greatest asset. We should learn, also, how great are the current losses from sickness and death. We have the knowledge necessary to do our share in the control of disease. We must put our knowledge to work here in our school and among our own nurses by advocating early treatment, immediate attention of what seem trivial symptoms and taking all possible preventive measures.

The cost in cold round figures of the medical treatment, hospital expense, and the loss to the student nurse is estimated in the following itemized bill.

Hospital care and room—6 days . . .	$28.00
Treatment room service	12.50
Drugs	1.85
Surgeon's fee, each operation, $25.	50.00
Surgeon's visit ($2.50 each for 8 visits)	20.00
Consultant's fee not included.	
Board and room	16.80
Laundry	1.50
Dressings and office visits to family doctor	6.60
Traveling expenses	6.46
Telephone	.65
Allowance for 15 days	10.00
	$154.36

During all this time I had to miss my classwork. The value of this cannot be reckoned in figures. The loss meant that I borrowed notes from other students. They were good notes, but I found that I lost a great deal by not being able to complete the outline in my mind as I do when I have been able to listen to the teacher and have taken my own notes. Copying notes also took time which I could have given to studying the new classwork I had to keep up with.

Let us learn now while in the school the rôle of the nurse in preventive work by learning to think prevention and apply it to ourselves.

This study of the effects of neglect and of care in what we ordinarily consider a minor illness shows us that we can learn the modern lesson of prevention on ourselves and then apply the knowledge we gain to the public whom we are going to nurse.

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Public Health in the United States, H. H. Moore.

The Open Forum

The editors are not responsible for opinions expressed in this department. Letters should not exceed 300 words; anonymous letters are not considered.

Is Higher Education Remunerative to the Nurse Educator?

MY first teaching position, immediately upon graduation, paid me just as much as my position since acquiring a college degree. My college education cost me time and money, but I find, to my regret, that institutions are not ready to pay nurses for this additional preparation. School-teachers are paid in proportion to their educational background, why not instructors of nurses? Is it worth the time and financial sacrifice?

I should never have gone on teaching had I not prepared myself for that kind of work. But since one does not get the proportionate compensation for this extra preparation, do not hospitals run the risk of discouraging higher education among nurse teachers?

I do not wish to appear too mercenary, but as I acquired not only knowledge but a neat little debt while getting my degree, I felt that better educational background should bring better compensation. Is my experience singular, or have other teachers found the same problem confronting them? I should like to hear others' opinions.

G. H., R.N.

Pennsylvania.

A Beautiful Pageant

MAY seems to have been the month of pageants, and quite appropriately so. The Alumnae Association of the Decatur and Macon County Hospital sponsored a very beautiful program. There was no charge for admission. The city responded by filling the auditorium, so that only standing room remained. The Illinois State Association owns the costumes which are loaned to schools of nursing which assisted in their preparation. It seemed a particularly appropriate celebration of Hospital Week, as well as of the tenth anniversary of the Alumnae Association.

A. F. A.

Decatur.

(The historical pageant given was entitled "The Inner Urge," and was divided as follows: Part I, Scene 1, The Conflict. Episode 1, Ancient Greece; Episode 2, Early Rome; Episode 3, Religious Nursing Orders: Modern Period; Episode 4, Dark Days; Episode 5, Deaconesses; Episode 6, Santa Filomena. Modern Nursing Review. Closing Book of History. Scene II, The Victory over Opposing Forces. Achievement.)

Journals *Wanted*

E. M. JAMIESON, Fabiola Hospital, Oakland, Calif., needs the following copies of the *Journal* to complete a file: 1915, October through December; 1916, February, September; 1918, July, November.

Journals on *Hand*

EMILY J. HICKS, Executive Secretary, New York State Nurses' Association, 370 Seventh Avenue, New York, has the following duplicate copies of the *Journal* which she will exchange or give away for postage: 1910, December; 1911, January; 1912, May; 1915, May; 1921, January through April, June through August, October through November; 1922, May through August, November, December; 1923, February through May, July through September, November, December; 1924, complete; 1925, June through December.

E. M. Jamieson, Fabiola Hospital, Oakland, Calif., will sell for 25 cents each and postage the following: 1923, October through December; 1924, March through June, September through December; 1925, February, March, July, August, November, December; 1926, January through April, June through September, November, December; 1927, complete; 1928, January, February, May through December; 1929, complete; 1930, January, February.

Mary L. Myers, 420 West 4th St., Oil City, Pa., will give away for the price of postage: June, 1920, to April, 1923.

Abstracts

J. B. Mosey, M.D., and G. E. Brown, M.D.: Newer Investigations for the Production of Fever for Therapeutic Purposes. *Staff Meetings of the Mayo Clinic*, November 27, 1929.

The value of fever therapy has been well established in the treatment of the occlusive forms of vascular disease affecting the extremities. As far as we know, its use was first suggested by Goodman and Gutterman in 1926; since that time we have used this form of treatment in the Clinic. Allen and Smithwick recently emphasized its value in these diseases. At the present time we believe that it is the best medical measure available in the treatment of diseases of the blood vessels; its effects are largely dual: (1) the vasodilating response on the part of the surface arterioles; this is easily measured by the sharp increases in the surface temperature which are of much greater magnitude than the increase in the temperature of the blood, and (2) its analgesic effect on the pain incident to trophic ulcers and gangrene. The relief of pain is most gratifying. Many of the patients suffering from thrombo-angiitis obliterans when first seen at the Clinic are in a pitiable condition; they are very nervous from loss of sleep and from excessive continuous rest or trophic pain. Many of them have been using large amounts of opiates. In the earlier days many amputations were performed because of the inability to control pain. During the last five years, with more adequate and intelligent use of fever therapy and the subjection of a certain number of the patients to sympathetic ganglionectomy, the incidence of amputations has been sharply reduced.

There are certain untoward effects in the use of fever therapy. Dr. Hench recently studied fourteen cases in which unusual or untoward reactions have followed the use of fever therapy. This represents all the reactions in more than 20,000 injections given in the Clinic. In two of the cases, thrombosis of [illegible] and tibial artery occurred; these patients were older or arteriosclerotic. The reactions are related to the chill phase which occurs when the usual vaccines are given intravenously. As a result of the recognition that there is an extremely small but definite risk involved in this treatment, we have undertaken a series of investigations to evolve vaccines that would, if possible, eliminate or minimize the chill in the fever reaction.

The nature of the problem was twofold: To produce fever without chill, and to be able to produce, if possible, a prolonged type of fever. In the last five years we have felt that Lederle's triple typhoid vaccine has been extremely reliable in that it produces a fairly constant reaction; most subjects react well to it. We have found through trial that many other triple typhoid vaccines lack adequate fever response or there is an abnormal amount of shock connected with its intravenous use. We were of the opinion that the nitrogen content of these vaccines might explain these difficulties in reaction; therefore, vaccines were prepared by Eli Lilly and Company with nitrogen content similar to that in Lederle's. Dr. E. C. Bartels carried out this research in the Clinic with intravenous vaccines of high nitrogen content. It was found that with paratyphoid B and triple typhoid vaccines with high nitrogen content less effective reactions were obtained than with the Lederle's triple typhoid vaccine.

The next step was to develop a typhoid vaccine containing type "O" antigen, which is thermostabile, present in large amount, inhibited by phenol and formalin and resistant to alcohol. In rabbits this produces fever without producing leukocytosis. It is likely that this antigen is a component of many different organisms. Type "H" antigen is thermolabile, inhibited by alcohol and not destroyed by phenol and formalin, and produces fever and leukopenia in animals. Typhoid vaccines containing the foregoing antigens were studied for their fever-producing qualities in cases of thrombo-angiitis obliterans. It was shown that both types produced a fairly constant rise in temperature and in both the chill phase was greatly minimized or absent, indicating that these forms of antigen represent a distinct improvement for intravenous use. There was practically no shock associated in their reactions. However, they are not quite as constant in their reactions as the Lederle's triple typhoid vaccine.

The third step was the development of a vaccine which could be used intravenously, one which would produce a [illegible] and if possible be given in a medium that would allow delayed absorption and [illegible] produce a prolonged type of fever. The [illegible] [illegible] and [illegible] some of this character have been developed by Eli Lilly and Company [illegible] of a [illegible] [illegible]. The [illegible] obtained by this method are satisfactory. [illegible] but the relief from pain and the [illegible] appears to be the [illegible] is fairly constant. The [illegible] from [illegible] to [illegible] [illegible]. This change in the [illegible] of the blood is apparently sufficient to [illegible] of the peripheral [illegible] up of the [illegible] of the [illegible]. The patient is conscious of [illegible] in the affected part. There is no disagreeable local reaction when it is injected in doses of 1 cc. in the buttocks and the patient is not conscious of chill. Other disagreeable reactions have not been noted. The vaccine is given every third day. The relief from pain comes out of proportion to the severity of the fever reaction. One hundred per cent relief from the pain of the [illegible] has been obtained in several cases after the second or third injection; elevation of temperature continues over a period of four to [illegible] hours. This form of treatment is, we believe, of much significance in that it has allowed us to treat with [illegible] older subjects with [illegible] [illegible]. Formerly we have not used the [illegible] forms of vaccine therapy in older subjects because of [illegible] of [illegible]. We have treated a number of [illegible] subjects without untoward effects and with distinctly beneficial results. We are inclined to the belief that the factor of safety here allows its extensive use in this type of case.

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A New Health Institute

A BILL has slipped through Congress almost unnoticed which will [illegible] in governmental [illegible] the National Institute of Health. This has long been the dream of Senator Ransdell [illegible] [illegible]. In addition to the backing [illegible] the American Medical Association, the American Public Health Association and various scientific bodies, the bill has the endorsement of Secretary Mellon and will doubtless be signed by President Hoover, who has always taken a special interest in scientific research and in government agencies to further it.

Under the Ransdell bill the Hygienic Laboratory becomes the nucleus of the new establishment, which will be devoted to the purpose of inquiring into the cause, prevention and cure of disease. The Treasury Department is specifically authorized to accept gifts from private sources for the furtherance of these investigations, much as the Library of Congress was authorized some years ago to accept donations in its field. A system of fellowships in scientific research has been devised in order to secure the proper personnel and to encourage men and women of exceptional proficiency to devote their efforts to the war on disease. While a great deal has been accomplished by the universities, medical schools and endowed institutions, their efforts have [illegible] [illegible] coordination. The idea is to make the Institute "a great cooperative scientific organization in which leading experts in every branch of science will be brought together and given an opportunity to work in unison for the purpose of discovering the natural laws governing human life."

The country's annual "human repair bill" runs to about [illegible]. That takes no account of loss of time or loss of life from preventable disease. Congress has appropriated vast sums for research in [illegible] [illegible], in animal and plant [illegible], and in the [illegible] and [illegible] of [illegible], but it has done comparatively little to further the science of human health. The workers in the Hygienic Laboratory have shown what could be done even with meager funds. With the far larger resources that the National Health Institute will ultimately command, it should be capable of doing much greater things.—Editorial in the *New York Times*, May [illegible], [illegible].

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[illegible]

Miscellany

The Crisis in Nursing

[illegible] is, in short, the one line of work [illegible] to the uneducated girl which will not only raise her social status and pay her [illegible] high wages but will provide her with a living while she is training and perhaps even a monthly allowance. . . . High school principals, when called upon for vocational advice, have been known to suggest nursing as a possible career for girls unfitted for anything else. . . . That nursing should have so fallen in the esteem of a portion of the community is largely the fault of those training schools which, in their anxiety to get the work of their hospitals done as cheaply as possible, have enrolled whatever young women were at the moment available. It is the fault, too, of the state legislatures which have [illegible] refused to raise the standards for [illegible] nurses. . . . The good training [illegible], maintain much higher [illegible] than the state laws require. . . . [illegible] of the schools have been [illegible] their entrance requirements [illegible] boards of directors of the hospitals [illegible] are not yet convinced that a [illegible] education is necessary for nurses. [illegible] boards do not realize that the [illegible] student may do fairly well [illegible] her superiors in training school, [illegible] when thrown on her [illegible] in private duty. . . .

[illegible] that employ inexperienced graduates [illegible] of nursing, and at [illegible] have the greater part of the [illegible] the supervision of wards [illegible] overcrowded students, are hardly [illegible] their patients. [illegible] a hospital there are [illegible] . . . [illegible] a [illegible]

[illegible] are not likely to prove [illegible] or totally [illegible]

[illegible] public unfortunately does not [illegible] the initials R.N. after a nurse's name mean that she is a graduate of an accredited training school and that she is practicing with the state's approval. Most people, I fear, think that a nurse is a nurse, and if a doctor is not at hand when they need one they turn to the telephone directory and call the first nurse registry they find listed. Now there are registries and registries. In most states there is at least one official registry sponsored by the State Nurses' Association. . . .

Until the states do protect the public against malpractice in nursing by exacting that all who practice be licensed, as doctors must be, it would behoove the public to protect itself by asking to see every nurse's registration card.

But neither the training schools nor the state authorities have it in their power to bring order out of chaos in the nursing profession, for the problem is fundamentally an economic one. . . . Unlike other professional workers, the private duty nurse's income level remains the same during the best years of her working life and then suffers a sharp drop. The beginner starts at the top and earns as much as the experienced and competent nurse, while the older woman, no matter how ripe her experience, is sure to find herself out of the running as soon as she loses her physical resistance. . . . The private duty nurse suffers not only from disadvantageous working conditions but she is suffering increasingly from a dearth of employment, as the training schools turn out larger and larger crops of nurses. . . . Popular belief to the contrary, there is at the present time no shortage of nurses in the cities and has been none for the past five years, except during periods of epidemics. . . . Yet there is no doubt that during the busy seasons there is often a serious shortage of well qualified nurses, and this is the reason why doctors talk of a general shortage. . . .

There is also a decided shortage of capable women to fill the positions of superintendents of nurses and supervisors in hospitals. In public health, too, there is a shortage of nurses who have had at least a high school education and have been well trained in bacteriology, the handling of contagious diseases, and the technic of asepsis. . . .

While the number of private duty nurses

has been rapidly multiplying, the number of persons who are in a position to employ this type of worker has been relatively diminishing. Preventive medicine is having its effects, and fewer and fewer people are going to bed for long periods of time. Houses have given way to apartments, and there is literally no longer any space for the private duty nurse. Doctors, too, are more and more inclined to send their patients to hospitals. The hospitals, in their turn, are enrolling more and more students to take care of the rising tide of patients and sending out more and more graduate nurses into the already overcrowded private duty field. A vicious circle to say the least. . . . If the standards of nursing are to be salvaged, a good many of the 2,300 odd training schools now in existence will have to be discontinued, and this will include most of those conducted by privately owned hospitals. . . . When there are fewer schools and when the requirements for entrance have been raised there will be fewer graduates and those of a much higher type. . . .

The greater number of patients in psychiatric wards and asylums have so far received only custodial care. Here is a field in which the nurse who is properly trained in psychology can be of immense importance in bringing patients back to normal, for it is she who is with them hour after hour. . . . There are a number of other fields of medicine—such as paralysis, orthopedic, pediatrics, and heart trouble—where the possibilities of nursing have not yet been fully explored. . . .

The days when women gave up their lives to nursing as they would to a sisterhood have passed. The best of the nurses today are animated by the same high ideals, but they see very clearly that the profession must be reorganized on a sound educational and economic basis before it can do all the things it has set out to do.—Dorothy Dunbar Bromley, in *Harper's Magazine* for July, 1930.

Better Writing

ANYONE wishing to improve his writing style will find of interest the list of books suggested in "English for Scientists" in the January Bulletin of the Rockefeller Foundation. The article points out that nearly everyone nowadays has to write, if only letters and reports; that clear thinking precedes clear writing; that if you wish to describe things better than the next man you will have to understand them better and observe them more clearly than he does.

Preparation of Scientific and Technical Papers by Trelease and Yule, published by the Williams and Wilkins Company, is suggested for those who are concerned with articles on scientific subjects. Specific advice is given on arrangement of material and preferred usage in the matter of abbreviations, citations, etc. Examples aid in making clear the authors' points.

Those who are interested in a general book on composition are referred to Edwin C. Woolley's *New Handbook of Composition* published by D. C. Heath and Company, or to Gratton and Gurrey's *Our Living Language* published by Thomas Nelson and Sons. Both give definite instruction in grammar, agreement of nouns and verbs, sentence structure, etc. The latter book "makes fascinating reading because its pages are peppered with well chosen, brief excerpts which show the charm and versatility of the English language."

According to the writer of the article in the Bulletin, the book *par excellence* for writers of medical articles is *The Art and Practice of Medical Writing* by George H. Simmons and Dr. Morris Fishbein, published by the American Medical Association Press. This presents not only general rules of style but also the special vocabulary which the medical man must know, with both English and foreign plurals, hyphenated words, and standard abbreviations.

For writers on other than medical topics, *A Dictionary of Modern English Usage* by Fowler, published by the Oxford University Press, is suggested. If an author wishes to know the steps through which his manuscript goes when it reaches the editor's desk he should have C. O. Sylvester Mawson's *Style-Book for Writers and Editors*, published by Thomas Y. Crowell Company.

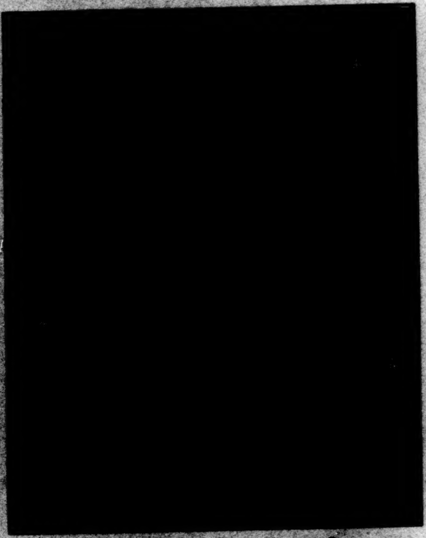
A more or less inspirational book is *Better Writing* by Henry Seidel Canby, published by Harcourt, Brace and Company. "Reading this book is like eating a cake." *Thought and Its Expression*, by George Carpenter Chase, published by Harcourt, Brace and Company is also recommended for its background value.—*From Michigan Public Health*, March, 1930.

High Lights of the Biennial

THE weather, the nurses, and the citizens of Milwaukee combined in a very perfection of hospitality which was in evidence the moment one stepped off the train. From the tower of City Hall, where a welcome to nurses shone forth each night, on down to the individual citizen and the individual nurse, no least thing was left undone that might add to the comfort or pleasure of the visitors. Homes and hearts were open to the visiting nurses.

The handsome Eagles Club with its beautiful oval ballroom was thrown open for the Wisconsin nurses' reception to their guests on Thursday night. The Kiwanians drove two hundred nurses over the lovely drive skirting Lake Michigan and through the city. The Over-Seas Service League gave a dinner for over two hundred Over-Seas nurses. Transportation to hospitals and nurses' homes was provided on Wednesday afternoon, in order that visitors might study the best and most interesting features of each, and this is but a sampling of the social activities of the week.

In the convention group itself breakfasts, luncheons and dinners filled the hours between meetings. One of the most important of these was the dinner of the private duty nurses, Anna C. Gladwin, Chairman of the Section, presiding. Speech followed speech, closing with those by Frances Ott, for five years Chairman of the Section, and by V. Lota Lorimer of Cleveland, who spoke of the profession as travelling over a highway which could be made smooth only by the concerted action of all those needing it. Probably this dinner, providing as it did for less formal discussion than the large meeting of the Section and the intensely interesting registry round tables, was helpful in crystallizing the thinking of the group into the resolutions later presented to the Board of the American Nurses' Association.



ANNA C. GLADWIN, R.N., OF OHIO
Chairman, Private Duty Section

Arrangements

THE Committee on Arrangements set a convention standard that it will be difficult for any other city to surpass or even to reach. The General Committee, under Miss El-[illegible] leadership, completed its work at an early date and on this was built an organization of committees which was extraordinarily successful.

Cornelia Van Kooy, the handsome and gracious President of the State Association, always smiling, never hurried, was constantly in evidence. Anna K. [illegible], Chairman of the Milwaukee Committee, set a beautiful example of the difference between poise and self-control. Always available, she was never hurried, never harassed. The committees all functioned.

Registration was accomplished with precision and dispatch. It is unfortunate that some of the nurse guests grumbled over the payment of one dollar for the privilege of registering. This has been an established custom for the past several biennials and is, of course, one important means of defraying the heavy expenses of the meetings.

The Auditorium proved, as promised, to be an ideal place for the meetings. Only occasionally was it necessary to use the ballroom of the nearby Hotel Schroeder. The Arena was more than ample for the largest gatherings. Amplifiers worked efficiently, so that speakers with well modulated voices were easily heard. A sufficient number of smaller halls and committee rooms were available.

On every platform at every meeting there were fresh flowers, gracefully arranged in big copper bowls set in high wrought iron standards. On the opening night there was also a basket of lovely yellow roses, gift of the Pennsylvania nurses, honoring the memory of Miss Clayton, who loved roses.

The Memorial Service

O[illegible]

[illegible]

A[illegible]

[illegible]

Miss Clayton, [illegible] that, [illegible]

[illegible]

[illegible]. The physician knows that his pa- [illegible] interested nursing care of [illegible] demanded. The organization [illegible] the community increasingly. [illegible] present themselves in the [illegible] policy in reference to types of [illegible] and in the administration [illegible] so that the number of nurses [illegible] shall not be excessive.

[illegible] the problem of how [illegible] service known has been con- [illegible] publicity, largely through cir- [illegible] is always undertaken. A [illegible] publicity at intervals [illegible].

[illegible] number of organizations have [illegible] plan on an entirely generalized [illegible] has been the case in Philadelphia. [illegible] paid for itself, the charge be- [illegible] the cost of a regular visit with [illegible] additional charges for the ap- [illegible]."

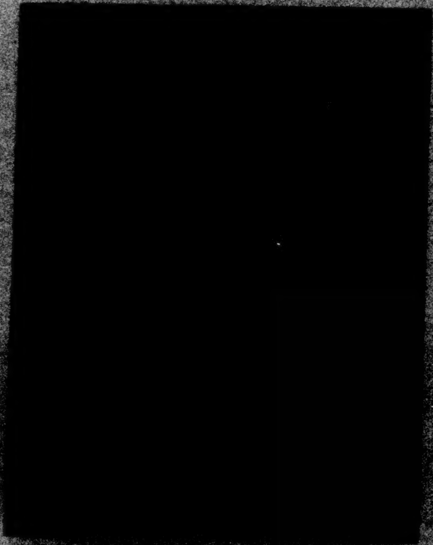
[illegible], Executive Secretary, First [illegible] State Nurses' Association, [illegible] "Hourly [illegible] the Registry Viewpoint," but [illegible] of a new type registry [illegible] than any now known. Miss [illegible] beyond the controversy over [illegible] nurse association as the [illegible] administer hourly or any [illegible] serve as a placement bureau [illegible] provide all sorts of nursing [illegible] community. Such a Joint [illegible] Nursing would be [illegible] only to extend nursing service [illegible]. Through research it would [illegible] community needs as well as [illegible] resources; it would [illegible], would coordinate [illegible] and nursing service; would [illegible] which have neither [illegible]. And [illegible] of the [illegible]

[illegible] of lack of time, the [illegible] could not be pre- [illegible]. The [illegible]

[illegible] Davis of the Julius Rosenwald [illegible] a member of the Executive Committee on the Cost of Medical Care, spoke on "The Citizen's Responsibility for Community Health." Said Dr. Davis: "Only three per cent of the national income is spent on medical care. The problem lies not in its size, but in the unevenness of the distribution of this cost." Elaborating on his theme, Dr. Davis said that it would require the united brains of all groups to solve the difficult problem of adjusting the load of costs. Complimenting nurses on their demonstrable contributions to both preventive and remedial nursing, Dr. Davis indicated that the solution of the riddle must come through the American genius for organization and that, just as saddlebag medicine is a thing of the past for the doctor, so is "the peddling of private duty service to doctors and patients" a thing of the past for nurses. "The organizing skill of American men and women will arrange so that trained nursing can be bought by the piece instead of by the person."

The essence of Dr. Burgess' address appears elsewhere in this issue.

Miss Goodrich was at her uttermost best in the brief speech with which this session closed. Said Miss Goodrich: "I had not expected to see the day when we should have enough nurses, and now I have begun to hope for enough qualified nurses." Characterizing this as a new epoch in nursing, Miss Goodrich said that it is one which needs not only education of the public, that universal remedy, but a Committee or Council in each community. Under such auspices we need to study carefully the nursing needs of the community and then to formulate a program by which those needs can be met. This might be accomplished by dividing the Council into committees to study various segments of the problem. We must learn to speak the language of the people, but we must also speak the language of science. We must study the hospitals, the content of courses, hours and conditions of work. We must evolve a standard in nursing which will attract college women to its ranks. Small communities may be helped by centralizing the instruction in scientific branches at suitable points, said Miss Goodrich. Boldly and dramatically she analyzed the problem of the small hospital. "Does the community need the small hospital? Is the [illegible] good? What is the quality of its service?" If the answers to these questions are in the affirmative, the small hospital, working through a centralized program, may be used as a practice field for students. Referring to her recent visit to the Orient, Miss Goodrich spoke of the high quality of the work being done at Pekin Union Medical



[illegible]
Who presided over the program on Work of State Boards of Nurse Examiners

College and of her eagerness to return to her own task of preparing highly qualified nurses for their important place in the world.

Of private duty nursing she said, "The best bedside instructors I know are the private duty nurses." We must see to it that their hours are shortened and their economics adjusted, for we are living in a democracy and each must have her chance for fuller development.

Legislation

LEGISLATION was the theme of several programs, and opportunity for informal discussion of problems was provided at a "Closed Luncheon" for State Board members. At a joint session Anna C. [illegible], whose State board work with the [illegible] of California, gave an exceedingly [illegible] of legislation [illegible] the past and [illegible]. "We may [illegible] the last three decades in [illegible] education through law enforcement and [illegible] to some degree, satisfied with the results accomplished. Yet at the same time we see many weaknesses and it is well that we should. What was considered adequate thirty or even twenty years ago is outworn today. Possibly our most needed reform is in [illegible] of one state with the other, and this means greater uniformity in requirements and more liberal interpretation of the law. The fixed length of course has been a barrier; time and not content has been stressed. Time might well be in the [illegible] and emphasis placed strongly on a minimum content and given within a period that can be adopted by all states. . . . Should the text of the law contain [illegible] basic requirements for the undergraduate and leave the specialties for graduate study? I am fully aware that I tread upon much debated ground when I bring up this question, but having been close to it for fifteen years I venture to express my idea that our concept of the undergraduate basic work in the school of nursing should be simplified and the burden lightened for the young student. This may be done by requiring the completion of secondary education, including the required basic sciences, before the student enters upon her nursing curriculum. Could this be done universally within the next five years one of the most important steps in nursing education would have been taken. It would [illegible] the nursing course in the school and clear the way for the application of scientific principles already learned in the study of the major, nursing. The completion of the undergraduate course and the confirmation by the R.N. will open the way to graduate study in the specialties."

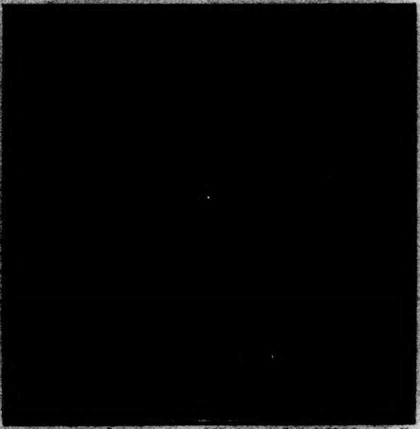
The paper on "Public Health Nursing Legislation," by Pearl McIver, Director of Public Health Nursing, Missouri, will appear in the *Public Health Nurse*. Mimeographed copies of a statistical study were circulated during the reading of the paper which showed that "forty states now have legislation which permits the employment of public health nurses by official agencies; twenty-three states have laws which permit local administrative agencies (city, town or township) to employ nurses for general public health work; [illegible] states have similar legislation for their [illegible], and twenty states authorize the employment of school nurses. Twelve states [illegible] work." Al[illegible] work."

The Legislative Section of the American Nurses Association held two meetings over [illegible] Thurlow of Massachusetts, the [illegible] presided, with Anna C. Jammé of [illegible] charge of the program of the [illegible]. In a paper on "The Effect of [illegible] Schools upon the Accrediting of [illegible] Mary M. Roberts, Editor of the [illegible] *Journal of Nursing*, stated that [illegible] about to enter the third stage [illegible] program, thus paralleling [illegible] of other professions; the three [illegible]: (1) Organization, (2) Legislation, [illegible]. Paying tribute to the [illegible] of state boards in the face of [illegible] obstacles of misunder- [illegible] Miss Roberts stated her belief that [illegible] should strengthen their existing [illegible] use of the findings of the Grading [illegible]. She further believes that the [illegible] far distant when the profession will [illegible] imperatively necessary to set up stand- [illegible] machinery which will be recognized by [illegible]. Graduates from schools so [illegible] might be and undoubtedly would be [illegible] examination by a National Board of [illegible] whose findings would be [illegible] to all states and thus abolish the [illegible] of reciprocity for graduates of [illegible] this upper level.

[illegible] Gladwin of Ohio paid tribute to the [illegible] and constructive work of state [illegible] Eldredge of Wisconsin pointed [illegible] have dealt, first, with individuals [illegible], with schools. Stressing the im- [illegible] of having the Attorney General of a [illegible] the law and thus provide a [illegible] basis for establishing board regula- [illegible] she indicated the splendid advances [illegible] high school requirements despite the [illegible] limitations of laws. Miss Eldredge [illegible] we should work for enrollment of only [illegible] graduates and that for such stu- [illegible] should be of college grade. [illegible] contended that legislation should [illegible] for inspection which gives oppor- [illegible] the right to advise, to secure con- [illegible] only with the faculty of the school of [illegible] with the training school commit- [illegible] interested groups, and that it [illegible] opportunity for setting up [illegible] equipment, standards of [illegible] standards of preparation for [illegible].

[illegible] paper, "The Use of the [illegible] Type in State Board Examina- [illegible] will be published at a later date, [illegible] discussion. The importance of [illegible] for those setting such [illegible] was pointed out.

[illegible] meeting of the Section was [illegible] brief papers, "Status of Foreign Nurses in States Not Having Compulsory Registration" by Anna C. Jammé, and "Requirements and Methods in Administering Reciprocal Registration" by Caroline V. McKee (Ohio), were the basis for animated discussion, as were the questions submitted to the succeeding round table over which Irene Murchison (Colorado) presided. The most striking fact brought out was that the methods of the various states differ widely. A summary of this material will be presented in a later issue of the *Journal*.



(*Underwood and Underwood*)

ELINOR D. GREGG, R.N.

Superintendent of Nurses, U. S. Indian Service, who presided over the Government Nursing Section meetings

Eugenia Kennedy (Indiana) was elected Chairman, Esther Tinsley (Pennsylvania) Vice Chairman and Ethel Swope (California) was reëlected Secretary.

Government Section

THIS Section had two meetings. Each of the four Government services was represented in the major program at which Elinor Gregg, Supervisor of Nurses, U. S. Indian Service and Chairman of the Section, presided. The meeting was truly an experience meeting in which the discussion illustrated the work of the several services.

The outstanding event of the meeting was the paper by Sister Martha Lawler, Chief Nurse, U. S. Leprosarium, Carville, La., where 326 patients from twenty-one states are now under treatment. Sister Martha fairly vibrated with enthusiasm for her subject, from the wings of her great white cap of the order of St. Vincent de Paul to the tips of her quick

[illegible]

[illegible] Navy [illegible] of the [illegible]

Mental Hygiene

[illegible]

The Presidents at Work

Left to right, Elnora E. Thomson, Acting President, A. N. A.; Elizabeth C. Burgess, N. L. N. E., and Anne L. Hansen, N.O.P.H.N.

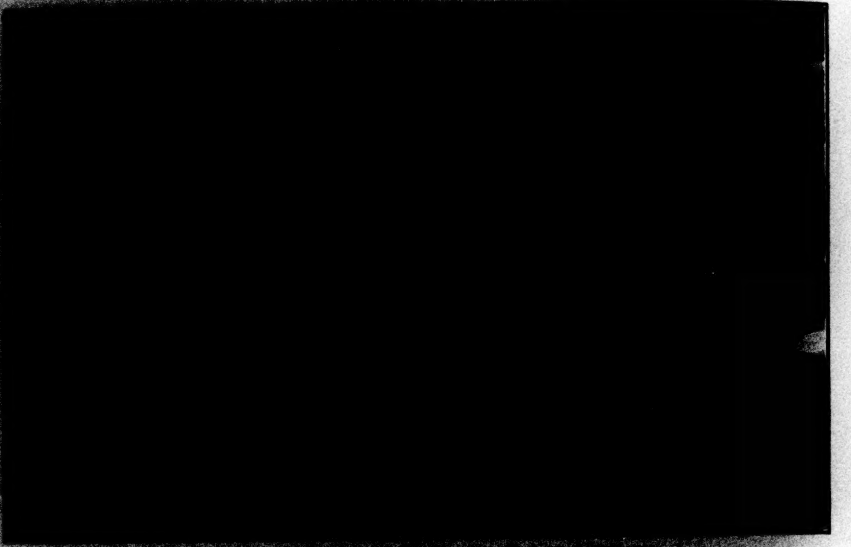
Much of the time the nurse is alone with the patient, [illegible] to work out the details of his care, and [illegible] she has actually the same point of view [illegible] understanding of treatment as the doctor, the care of the patient is not efficacious and the [illegible] of the patient is jeopardized. On the other hand, quite frequently do mentally [illegible] patients recover their lost balance through the good quality of care given by [illegible] and intelligent nurses. [illegible] we see the general hospital [illegible] for itself a more complete [illegible] of its patients. It is recognized [illegible] physical disturbances are no [illegible] than mental deviations in [illegible] of the patient. The more [illegible] hospitals are teaching [illegible] their own specialized [illegible] skilled professional staff. [illegible]

Mary D. Taylor, Bloomingdale Hospital, closed her admirable paper on "The Emotional Adjustment of the Student Nurse in Psychiatric Work" with: "The nurse, even with ideal preparation, is not 'finished off' as a perfectly functioning instrument. She, too, is human, with her own problems, emotional conflicts and desires. Adjustment in some situations is extremely difficult and a sympathetic understanding attitude, with perhaps some personal guidance, is more efficacious than criticism or censure. We urge the understanding of patient and proper mental hygiene for the general public and often neglect to practice it upon the group whom we expect to carry on this work. That psychological poise and calm which was referred to earlier as essential in the good psychiatric nurse can be attained only as the nurse is freed from her own entanglements and given some understanding of her own problems."

Officers elected were: Chairman, Effie J. Taylor, Yale School of Nursing, New Haven, Conn.; vice chairman, May Kennedy, 6400 Irving Park Blvd., Chicago, Ill.; secretary, Anna K. McGibbon, Butler Hospital, Providence, R. I.

Private Duty

PRIVATE DUTY nurses were busy people at the convention. Many of them were delegates charged with the responsibility of attending business meetings and of carrying home a comprehensive report of the proceedings. They were also deeply interested in the unusually interesting programs based on their own broad field, for two sessions were devoted to



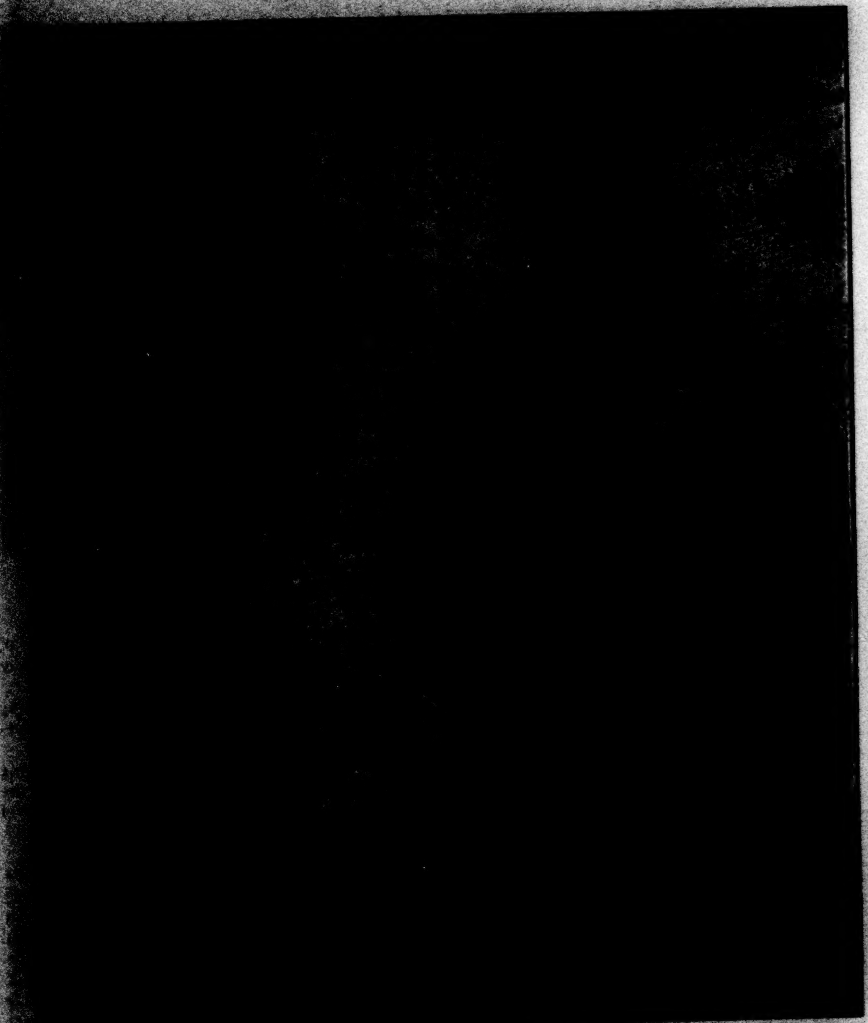
The A. N. A. [illegible]
Fresh flowers were kept constantly before Miss Clayton's picture

the Private Duty Section, two splendidly organized Round Tables, which were of the proportions of sessions, on Registries, and the Private Duty dinner. This was one of the largest affairs of the convention. Agnes Jamieson, Chairman of the Private Duty Section of the Canadian Nurses' Association, was a guest speaker. Among other speakers were S. [illegible] Dozier of California, Helen Gregory of Pennsylvania, Frances Ott, Sec. Chairman of the Section, and Rose [illegible] of Ohio. So intense was the interest that the dinner lasted far into the evening and the group missed the Wisconsin Nurses' reception at the Milwaukee [illegible] Club. Undoubtedly this dinner had a strong influence on the thinking of the whole group, making it possible to formulate an important Resolution which was presented to the Board of the American Nurses' Association for further action. The recommendations contained in this Resolution were that the Board should provide for:

1. The appointment of a private duty nurse on all standing committees.
2. Amend the by-laws so that the chairman of the Private Duty Section should become a member of the board.
3. Pay expenses of secretary of Private Duty Section at conventions.
4. Request each state association to pay expenses of chairman and secretary of State Section on Private Duty Nursing to annual meeting.
5. Request the *American Journal of Nursing* to add names of state chairmen and secretaries to Official Directory.
6. Request the National League of Nursing Education to reduce in the near future the number of students in the schools of nursing.

This Resolution with its recommendations, we understand, will be referred to a very carefully selected committee for consideration.

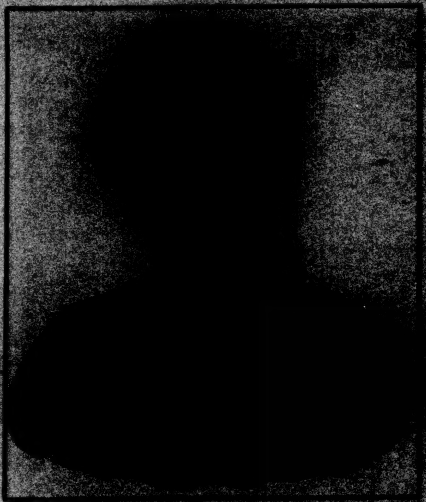
Both meetings of the Section were presided over by the chairman, [illegible] of Ohio. Helen Gregory (Pennsylvania), speaking on [illegible] Private Duty Nurse De[illegible], said in part: "[illegible] if she is [illegible]. It is [illegible] should [illegible] their [illegible] the [illegible] who [illegible] true [illegible] Miss Gregory added, "[illegible] who do only special nursing in the hospitals be called



[illegible] Exhibit

private duty nurses." It would be interesting to know how many thousands of nurses such a ruling, if it could be made, would automatically remove from the ranks of private duty. [illegible], probably, to reduce private duty from its [illegible] place in numerical strength, if registry [illegible] [illegible].

Miss [illegible] Wolf of San Francisco gave a thought-provoking paper on "The Bureau of Nursing Service," in which she maintained that, "The future of the Bureaus of Nursing Service lies in the hands of those who are responsible for them. The possibilities for good are vast, indeed. The usefulness of the bureau may be increased by furnishing the particular type of nurse service that will fit the community's needs. Twelve and twenty-four-hour special care have reached the



[illegible]

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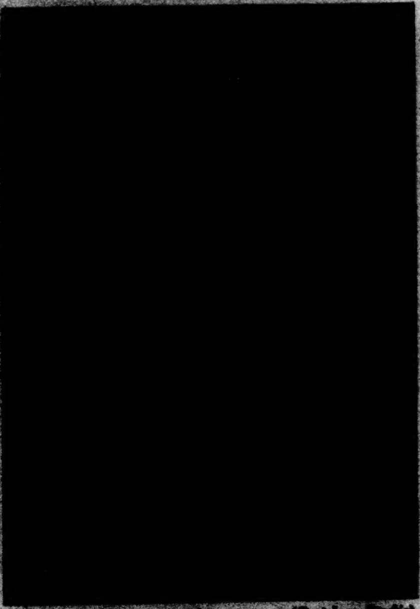
[illegible]

[illegible] the boys to some anxious private [illegible]. At the first of these Round T[illegible] Van De Vrede (Geor-[illegible] J. [illegible], Superintendent [illegible] Hospital, Chicago, spoke on [illegible] from the Angle of the [illegible]." Conceding at once the [illegible] of the special duty nurse as a [illegible] to the hospital service, [illegible] stated that most of the difficul[illegible] the two were due to lack [illegible] and interest. Among the [illegible] to the "specials" he [illegible] (1) suitable dressing rooms and [illegible] nurses could have some [illegible], and (2) good food well [illegible] thought that it should [illegible] and general rules for "spe-[illegible] with the registrar. He [illegible] "specials" should own a [illegible], support the rules [illegible] openly is always in bad taste, [illegible] the nursing of students, and [illegible] complaints to the appro-[illegible]. He closed with the [illegible] a hospital is not really a [illegible] it is pervaded by a spirit of [illegible]

[illegible] Schmidt of Chicago followed [illegible] and constructive discussion of "[illegible] from the Private D[illegible]," which we hope to publish in an [illegible], therefore, will not summarize [illegible]

[illegible] half of this period was devoted [illegible] Relationships." Mary Mar-[illegible], Indianapolis, stated [illegible] has not one problem but [illegible] with: (1) the nurses who [illegible] registry membership; (2) the [illegible] whom the registry members go [illegible] care is needed; (3) the [illegible] who call private [illegible] their patients; and (4) the [illegible] whom care is given and who [illegible]

[illegible] has been and [illegible]



([illegible] Studio)

Jeanette Hays, R.N., of Wisconsin
Chairman, Round Table II

nursing" and, further, "Public education is two-thirds of any game and must receive thought and attention if any amount of success is hoped for." Despite her keen appreciation of the many problems, Miss Muckley closed on a high note of aspiration.

Of the "Relationship of the Registry and the Private Duty Nurse," Lena M. Schmidt (Detroit) said: "The obligation of the registry is to supply calls to the nurse in a fair and impartial manner. The obligation of the nurse is to be ready, after she registers, to receive and execute these calls promptly and efficiently." Of one phase of coöperation she said: "There should be frequent meetings of registry and private duty nurse, as no coöperative enterprise can exist without frequent meetings for consultation and advice from both parties concerned. As to the method of assignment, it has become a rather fixed custom in the official registries to list nurses as they register. This is not coöperative because the nurse is not always sent on suitable cases, thus adversely affecting both nurse and community."

Miss Schmidt offered four suggestions for the improvement of conditions:

Emma M. Henderson, R.N., of Milwaukee, Chairman of Entertainment Committee. Miss Henderson is also President of the Board of the American Journal of Nursing

1. Some plan of grading private duty nurses and then assignment of duty according to merit.
2. Opportunity for growth, afforded by compulsory attendance at at least 75% of Section meetings for two years after joining the registry.
3. Constructive leadership which would be developed as the nurse grows in group consciousness resulting from attending the Section meetings.
4. Some plan by which the registrant and the registrar meet at stated intervals to discuss their mutual problems.

Registry Round Table No. II was presided over by [illegible] Hays, the [illegible] Director of District Headquarters, Milwaukee. All of the papers, with the exception of that by [illegible], which we hope to publish later, appear in this issue.

Discussion at both round tables was spirited. It was stimulating to hear a private duty nurse, who had for a time practiced another specialty and then returned to private duty, state that special duty conditions, in her [illegible], had "markedly improved" in the [illegible] years. Surely such progress and discussion will help "push back the dark" of [illegible] and bring about a better [illegible] for cooperative effort in adjusting the [illegible] problems of the private duty nurses.

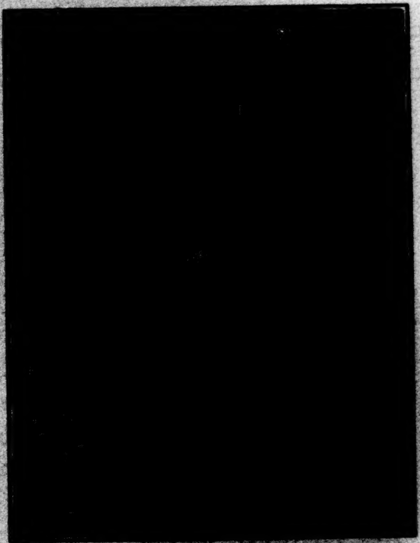
At the final session of the Private Duty [illegible], again with Anne C. Gladwin presiding, the Private Duty Section of the Wisconsin [illegible] put on an exceedingly clever dramatization of "A Day in a Registry," conducted [illegible] and with other students taking the various parts. This was a part of the presentation of the subject "How To [illegible] a Program." Mimeographed outlines [illegible] material for meetings were circulated. Under the general headings are listed [illegible]: (1) The Official Registry, Its Functions, [illegible], Administrative Methods, [illegible]; (2) Contagious Diseases, Prevention, Control, Care; (3) Home Nursing, Technique, Procedure, Cooperation, Topics for Meetings; (4) State Aid for Nursing Education; (5) [illegible] and Investments; (6) Psychiatry and Psychiatric Nursing; (7) Group Nursing, [illegible], Definition, Viewpoints, [illegible].

Janet M. Geister, Director at Headquarters of the American Nurses' Association, who has devoted a major portion of her time to this branch of nursing since her appointment as Director, likened her work to that of a [illegible] planter, since it seems necessary to [illegible] before people will think. With deep sympathy she analyzed the problems of private duty nurses today, stating that [illegible] prevalent [illegible] in all groups [illegible] of all the problems of society, is the most serious [illegible] private duty nurses. Although the [illegible] is often con- [illegible], she [illegible] are a [illegible]. In the [illegible] but [illegible] up" [illegible] gradu- [illegible] to [illegible] these [illegible] pro- [illegible] pro- [illegible] into [illegible] belief [illegible] and [illegible], but she believes we can go much [illegible] we yet have in this line. Dis[illegible] charge "no one does anything for [illegible] duty nurse," Miss Geister pointed [illegible] the steady efforts of the national [illegible] find answers to the problems and [illegible] nurses to formulate their needs in [illegible] in order that they might have [illegible] others find good, such as reason[illegible] adequate income and opportunity [illegible]. Miss Geister concluded by say[illegible] way to get things is: (1) belong to [illegible]; (2) participate actively; (3) de[illegible] you want; (4) work out a practical [illegible] getting it; (5) ask the organization [illegible] it." In conclusion, Miss Geister [illegible] us put our hearts together in [illegible] and mutual understanding."

[illegible] *Nurses and Anesthetists*

[illegible] first time these two increasingly [illegible] groups of nurses had a place on [illegible] and an interesting place it was! [illegible]ly 200 nurses enjoyed the pro[illegible] Miss Annie M. Beddow, Anesthetist, [illegible], was general Chairman.

[illegible] Fulton was the delightful presiding officer for the portion of the program devoted to office nursing. Frances Pederson spoke of it as "this embryo section of the American Nurses' Association." In her paper on "Growth and Development of Office Nursing" Miss Pederson brought out the point that, although there have been office nurses for twenty years or more, this is the first time the group has had official recognition. "We find many classifications in our work," said Miss Pederson, "nurses who execute all nursing and business management with an assistant for reception room service, nurses who execute all business and nursing management without other help, nurses whose duties are purely professional, many of which are routine laboratory work, x-ray work, assisting in operations, doing [illegible] at hospitals where no internes are [illegible], making house calls where special [illegible] is needed, and the administration of anesthetics." To be successful in this [illegible], Miss Pederson believes that "a [illegible] qualified office nurse must be an [illegible] nurse; one who understands the [illegible] of the physician employing [illegible] must be neat and always have to [illegible]. Good reading is [illegible], because she will know what is [illegible], know what to prepare for the [illegible]. If an operation is to [illegible] she should know all necessary [illegible] instruments needed, be able to act in an emergency until he arrives, have patients ready for examination and treatments so his valuable time will not be lost. She must also remember at all times to be loyal and faithful and to use discretion."



Annie Mae Beddow, R.N., of Alabama
Chairman, Round Table for Office Nurses and Nurse Anesthetists

In a paper on "The Strategic and Professional Position of the Office Nurse," written by Blanche Fulton and read by Mrs. Lola Armstrong of Los Angeles, the question was raised, "Is the office nurse a business woman or is she a professional nurse?" Making the point that the office nurse is closer to the physician than any other and in a position to influence his thinking for or against a shorter day for private duty nurses, for or against better educational programs, Miss Fulton urged that closer bonds of fellowship be forged between this group and the profession as a whole than in the past for, said she, "a proper recognition of the office nurse but welds another link in that great chain known as 'Together.'"

Josephine Locum of Minneapolis presided over the Anesthetist's portion of the program. Agatha Hodgins' paper on "The Nurse Anesthetist" is given in full in this issue. Presenting "Some Problems of the Nurse Anesthetist," Rosalie McDonald, Wesley Hospital, Atlanta, said that "lack of coöperation on the part of the surgeon" is the most important

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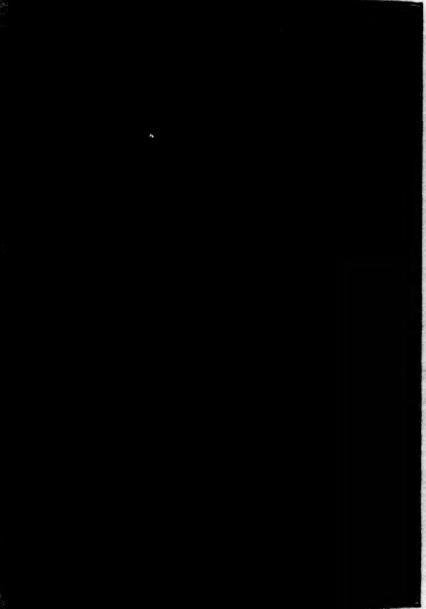


[illegible] ALO
[illegible] Public
[illegible]

[illegible]

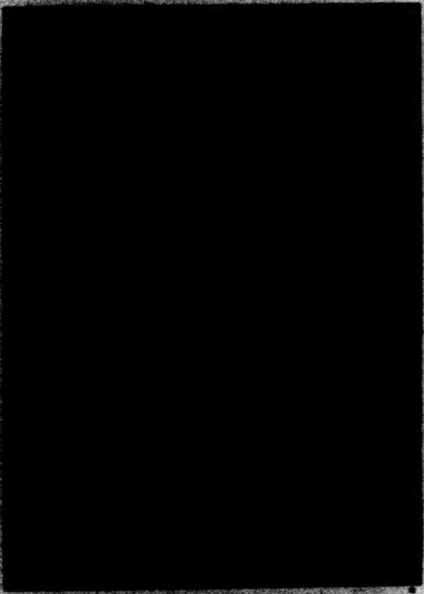
[illegible] Milwaukee Convention, was [illegible].

[illegible] Professor of Sociology at [illegible], discussed the subject [illegible] Professional People," dealing [illegible] insurance against sickness, [illegible] disability and old age. [illegible] methods of insurance are [illegible]: "First, individual purchase [illegible] private company; second, [illegible] as in the case of workmen's compensation [illegible] individual accidents; third, [illegible] of insurance from a private company; fourth, mutual insurance [illegible] through its own organization." [illegible] pointed out that group insurance [illegible] if the people in the [illegible] insurance unit will have [illegible] a plan of such mutual insurance [illegible] administered through the [illegible] of nurses [illegible] paper will be made available [illegible] through the Head[illegible] of the American Nurses' [illegible]

[illegible] of the Relief Fund was so active [illegible] was adjourned to another [illegible] when the discussion was con[illegible]. All state associations had received a [illegible] prepared statement from the [illegible] in April, and many of them sent [illegible] prepared to contribute new plans [illegible]. These tended to center on a [illegible] to the states or to the dis[illegible] more carefully prepared ones, [illegible] of California, provided for in[illegible] the [illegible] accepted in modern [illegible]. At least one of them, the New [illegible] provided for an additional [illegible] Headquarters.

[illegible] from frank criticism of [illegible] professional relief giving [illegible] professionally, systematically [illegible] a form [illegible] which [illegible]

[illegible] of the Ameri[illegible]



JANE VAN DE VREDE, R.N., OF GEORGIA
Chairman, Registry Round Table I

American Nurses' Association Election

CANDIDATES for office never displayed finer spirit than the various nominees for President of the American Nurses' Association. Elnora Thomson (Oregon), First Vice President, had declined the invitation to allow her name to be placed in the ballot for President. Jane Van De Vrede (Georgia) and Mary E. Gladwin (Ohio) were so named. Julia C. Stimson (D. C.) was nominated from the floor. Miss Clayton's death brought Miss Thomson to the office she had so modestly declined. Presiding in an extraordinarily selfless spirit, it became apparent that the First Vice President might, if elected, carry on the work of the organization with a minimum of readjustment, since she had already informed herself on details of the arduous administrative responsibilities. When, therefore, Miss Thomson's name was placed in nomination, the other candidates withdrew. Miss Van De Vrede and Miss Gladwin were then nominated for First Vice President. Neither received a majority vote and the matter was referred to the Board for decision. Again Miss Gladwin magnanimously withdrew, stating that she believed the fourth should have [illegible] [illegible].

[illegible] [illegible] [illegible] was elected [illegible] Vice President; [illegible] [illegible] R. [illegible] [illegible] [illegible] [illegible] Treasurer. [illegible] [illegible] (New York) [illegible] [illegible] [illegible] [illegible] for [illegible] [illegible] [illegible], was elected [illegible] to serve [illegible] Alice [illegible] (Wisconsin) and [illegible] C. [illegible] (D. C.).

Education and the N. L. N. E.

EDUCATION as the basis for all professional [illegible] was the [illegible] upon which the [illegible] program of the [illegible] [illegible] was [illegible]. The [illegible] on [illegible] night had as its theme, "[illegible] [illegible]."

Dean [illegible], of the College of Liberal Arts, Northwestern University, presented a [illegible] Dr. [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible], of education, but so as to overlook the processes of mental growth and the great variety in educational change." The development of what has been called "the patchwork stage of education" resulted, according to Dr. [illegible], in a culture which borders "breadth of knowledge rather than depth." The extreme swinging of the pendulum, resulting in the addition of an enormous number of subjects to the curriculum, brought about the elective system and later sequences of courses in order that no student might graduate who had not done "advanced study in some chosen line of work."

With the addition of the physical and biological sciences "the laboratory had come to stay." Almost at the same time Langdell introduced the case method into the study of law at Harvard. "The slogan of the laboratory and the case method was 'contact with things studied.'"

The applications of the findings of the psychologists to educational theory are only beginning to be apparent, according to Dr. [illegible], and "the social sciences, even though relatively undeveloped, have warned us that the accumulation of habits, of customs and of traditions, is a slow process extending over many generations. It is in this field that I believe one of the greatest changes in educational outlook is taking place," said the speaker, and concluded: "Therefore I have undertaken to warn the nursing profession against too hasty generalizations regarding their curriculum and the forms of teaching now available. The relations which the forms of service rendered, the financial returns to be expected and the social significance of the profession are to bear to the time spent in preparation and to the nature of that preparation, are not clearly indicated in existing social theory. What then seems to be indicated is scientific caution in accepting plausibly set forth proposals and strenuous thinking in building wisely for a more distant future than educational theory and practice have habitually done."

[illegible] [illegible], Adviser to the Joint Committee on Educational Policies, who has since January been working in coöperation with the Grading Committee, presented an able paper on "The Community and Nursing Education," which will appear in an early issue of the *Journal*.

The President, Elizabeth C. Burgess, presided over a general session at which the "Selection of Students and Student Adjustments" was the topic. The material presented shows that at least a beginning has been made toward bringing in experts in other educational fields to help in nursing school problems.

According to Roy [illegible], University Examiner, University of Chicago, admission to college is becoming a very refined process and many of its factors could be considered by nursing schools. College admission boards also have evidence which would be valuable to our own schools. The problem has become more acute of late because of the great increase in the number of students in secondary schools; there were nine times as many high school students in 1920 as in 1890 and twice as many in 1926 as in 1917.

He considered two phases of the problem of admission: (a) general factors determining standards of admission, and (b) the elements of a good system of admission.

Under (a) should be considered the aims of the school, and the source of its support, e.g., whether public or private, more rigorous standards being justified in the latter.

A good system of admission should consider:

1. The scholastic preparation of the student: the kind of high school, the type of high school curriculum, the quality of scholarship—[illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] [illegible].
2. Scholastic aptitude tests. Such tests are

[illegible] 12 years old, but are important, [illegible] it seems more just to refuse admission on the basis of such tests rather than to dismiss the student at the end of [illegible] for poor work.

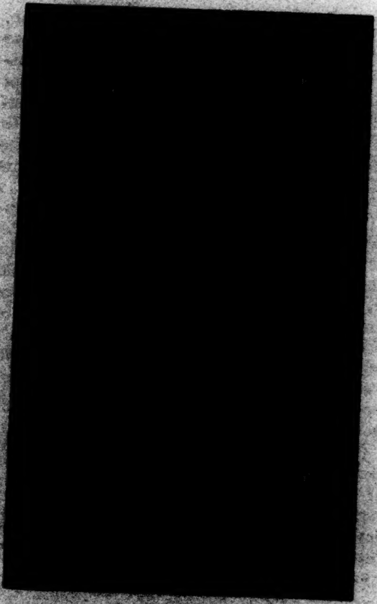
3. [illegible] aptitudes including moral and [illegible] qualities.
4. Health, including neurotic tendencies tests.
5. Financial status.

Mr. [illegible] urged personal interviews as a part of the admission program as an aid in determining these factors and feels that retention of students should be as selective as their admission. While these standards may seem [illegible]cratic, it is for the school to decide what kind of clientele it wants and select students with that end in view.

[illegible] K. Root, Dean of Women, Wooster College, Ohio, considered four types of problems under the general topic of Student Adjustments. These are: economic, intellectual, social, inner and spiritual. It is often difficult to help students overcome their problems, because often they do not know that they have them. At Wooster College the activity of the Dean of Women is [illegible] by the Senior Council of twelve senior students, each of whom is responsible for knowing from twelve to fifteen freshmen. Weekly meetings with the freshmen are held by each member of the Council, who in turn are met frequently by the Dean to discuss such problems as friendship, study, [illegible], etc. Not only is this group of [illegible] to the Dean and the freshmen, but their qualities of leadership are developed by [illegible].

[illegible] Wheeler, Washington University, speaking of the "Selection of Students for Schools of Nursing and Problems of Adjustment," gave results of a study of ten states [illegible] that the majority of students who drop out do so in the first year. At Washington University 60 per cent of students [illegible], 27 per cent resign, and 13 per cent [illegible]. In other schools 87 per cent [illegible] that there is great waste in [illegible] systems of our schools. [illegible] urged research in terms of [illegible] traits and suggested that a [illegible] who could interview applicants [illegible] would be one [illegible] and eliminating [illegible] later.

[illegible] presided also at the session [illegible] Affiliations" was [illegible]. The papers by Marion [illegible] (Bellevue) and Cassie M. Hall (Peter Bent Brigham, Boston) appear in this issue.



Elizabeth C. Burgess, R.N., of New York
President of National League of Nursing Education

The general session on Friday presented one of the most stimulating programs of the entire week, and results must be far-reaching, both because of the practical and illuminating analysis of the "General Functions and Organization of Supervision," by Dr. W. H. Burton, Professor of Education, University of Chicago, and because Mary Marvin's study of the "Supervision of Clinical Instruction" showed that for the most part, in nursing schools in this country, supervision as a teaching function scarcely exists, and that head nurses and supervisors instead spend the greater part of their time in administrative and purely nursing functions. In a sense, then, as a result of these two papers we know where we stand in supervision and how to go ahead in improving that supervision.

Dr. Burton defined supervision as an expert technical service designed to improve the efficiency of the groups supervised; its large purpose is to improve the quality of instruction (a) by promoting professional growth and (b) by correcting deficiencies of early training.

[illegible]

[illegible] and to poor management. The [illegible] great discrepancies between [illegible] head nurses doing the same work [illegible] wards.

[illegible] for improvement were: (1) [illegible] staff for floor duty; (2) arrangement [illegible] conferences; (3) better selection [illegible] and supervisors; (4) in-service [illegible] these groups. The values of in- [illegible] for head nurses and super- [illegible] the fact that the new head nurses [illegible] is expected of them; students do [illegible] head nurses change; the super- [illegible] the plan as a whole and not that [illegible] only.

[illegible] for research studies were: (1) [illegible] cost studies; (2) traits and [illegible] essential to head nurses and [illegible] (3) determination of the indica- [illegible] size of departments supervised; (4) [illegible] the size of the ward in charge of [illegible] (5) rating scales for evaluating [illegible] work; determination of standards [illegible] supervision; (6) methods of evalu- [illegible] quality of nursing care, including its [illegible] aspects; (7) health teaching and [illegible] understanding of the individual [illegible]

[illegible] these two papers Margaret [illegible] Western Reserve University, [illegible] again the changing conception of [illegible] from administration to teaching. [illegible] application of Dr. Burton's [illegible] the field of nursing, urged that [illegible] be given supervisors in which to [illegible] out the need for more trained [illegible] and showed that developing [illegible] as leaders is the work of the [illegible]

[illegible] general discussion which followed, [illegible] whether it is better to [illegible] a small number of [illegible] staff combine the teaching of [illegible] the administration of the ward, [illegible] persons (in a larger unit) each [illegible] functions. Dr. Burton pointed [illegible] it is possible to find [illegible] combined in one person. [illegible] Miss McMillan pointed out, is the lack of funds which most schools have to contend against. Endowments must be built up for the school and funds made available with which to employ graduate nurses for floor duty. At the Presbyterian Hospital, Chicago, it has seemed best to experiment on some wards, having two persons on the ward for teaching and administration, the superior being responsible for both teaching and administration but delegating what seems best to her assistant. This is frequently a matter of personality.

At the Session conducted by the Education Committee at which Anna D. Wolf, University of Chicago, presided, Roy Sorenson, Regional Executive of the Boys' Work of the Y. M. C. A., Chicago, discussed "Staff Conferences and Conference Leadership." It was a very practical discussion of group activity as an expression of twentieth century life which makes it necessary to work out new methods of teaching. The adult education movement brings in new factors: the felt needs of the individual and his experiences. Also more is known about how learning takes place.

The advantages of the staff conference method are: (1) efficiency in securing learning because the participants are active, the subject matter is dealt with in situation form, and reasoning has replaced memory; (2) appreciation of new problems and people is created; and (3) the participants get a new sense of the worth and dignity of their own thinking. This last is of prime importance.

Suggestions for conducting conferences are: (a) small groups; (b) encourage discussion; (c) demonstrations by the teacher or member of the group; (d) make material concrete; (e) have group sit about a table so they may see each others' faces; discourage straight rows of chairs; (f) don't be grimly purposeful; provide for informality; (g) find out members' problems and emotional reactions through questions, base agenda upon results of these; (h) prepare carefully for the conference, questions, summaries; indicate resources as books, etc.; consider mental hygiene of evasions, intelligent leaders, etc.

At the same session D. Dean Ursh presented the "Functions, Values, and Methods of Conducting Staff Conferences in a School of Nursing" as worked out in the Highland Hospital School of Nursing, Oakland, Calif. It was a practical, concrete, and non-theoretical discussion of what is actually being done.

Miss Ursh feels that the need to develop leaders is one of the first reasons for having such conferences. They also give the staff member an understanding of the aims of the school, broaden her outlook, develop her ability to cooperate, give her the joy of sharing in the larger plan, standardize technics and [illegible] the people carrying them out, and co-ordinate theory with practice.

To be successful staff conferences must be [illegible], each member [illegible], programs must be planned and published in advance, they must not [illegible], the presiding [illegible] should be changed often, the conferences must be held in "on duty" hours and away from the telephone, provision must be made for all staff to be present, and tea should be served [illegible].

Some valuable suggestions as to content of such conferences were demonstration of new technics with a committee to study and report on [illegible] study of [illegible] [illegible] [illegible] nursing [illegible] and [illegible] [illegible]. [illegible] [illegible] [illegible] [illegible] of nursing [illegible] [illegible] [illegible] [illegible] opportunity to see the problems of the young student. Case method is [illegible], policies and plans and [illegible] reports are discussed, articles and books reviewed, other departments of the hospital described.

The values of staff conferences are: (1) dignifying of the position of the supervisor who is then enabled to take leadership responsibility; (2) university extension work is encouraged; (3) there is more pride in and loyalty to the policies of the school; (4) standardization of technics and equipment is achieved; [illegible] the staff members come to have the desire to have the things which they have worked for.

Amelia Grant, New York Department of Health, pointed out that though staff conferences began in public health nursing as a supervisory aid, they have come to be an educational program. Decisions made in conferences must be put into action and it is important that the group know [illegible] [illegible] they have and [illegible] [illegible] [illegible] recommendations. Individual [illegible] show up in staff conferences [illegible] because [illegible]. [illegible] [illegible] [illegible] own ability, it helps the [illegible] [illegible] her, helps [illegible] [illegible] of the individual and improvement in the quality of service.

Ruth [illegible], Western Reserve University, presided at the meeting conducted by the Instruction Section. "Testing" was the general theme. The paper "Objective Methods in Classroom Tests" appears in this issue.

Pretests, if carried out consistently, would have great influence on the curriculum of schools of nursing and might effect important economy in time. Margaret O. [illegible], Instructor and Supervisor of Medical Nursing, Western Reserve University, gave an intensely interesting paper on "Pretests in Schools of Nursing Curriculum." The purpose of such tests is to prevent duplication of material in different courses, particularly those coming late in the course; for instance, in a pediatric pretest, 85 per cent of the questions covering the entire course were missed by less than 20 per cent of the students. Pretests also show at what points greater teaching emphasis should be placed, and where particularly strong connections should be made between theory and practice. As much as 30 per cent of the teacher's time is spent on material with which students are already familiar.

Pretests should cover the subject matter usually covered in the course. While individual scores were not considered in the experiments at Western Reserve University they could be made use of. Questions missed by only 20 per cent of the class can be covered by outside reading, etc., but need not have special class emphasis; those missed by 50 per cent of the class must be given great emphasis.

Pretests are valuable because they show the student the bearing of her high school subjects on the course in hand; show her the relation between courses; and what she should look for in ward experience.

The paper by Edith Potts on "Testing the Outcomes of Clinical Teaching" will be available later.

[illegible] was elected Chairman of the Section for the coming year and Nell Goody, Secretary.

The eagerness of League members for exchange of opinion and [illegible] of [illegible] was clearly demonstrated by the [illegible] [illegible] [illegible] for the conferences [illegible] [illegible] [illegible] and [illegible]. [illegible] [illegible] [illegible] hour [illegible] [illegible] at [illegible] [illegible] [illegible] L. [illegible] [illegible] that [illegible] type [illegible] the [illegible] [illegible] [illegible] [illegible] [illegible] [illegible] Ob-

[illegible] these principles are applied to [illegible] records, such records must be [illegible] complete.

[illegible] presented from the experience of [illegible]:

1. [illegible] for records come from so many [illegible]: colleges, universities, state [illegible], schools of nursing giving [illegible] courses and agencies or institu[illegible] graduate nurses.

[illegible] information is asked for in [illegible] ways. This requires inter[illegible] of school records in terms of the [illegible] sought. Because of her famili[illegible] the records and her understanding [illegible] this usually devolves upon the [illegible] of nurses.

[illegible] state boards require as much or [illegible] information as do colleges and [illegible]

[illegible] graduate may require several rec[illegible] transcribed in exactly the same [illegible] university, registration by reci[illegible] another state, and application for a [illegible]

[illegible] of students graduating twenty [illegible] years ago must be evaluated by [illegible] who know the situation as it was [illegible]. The records are inadequate.

6. Expense of time and energy.

[illegible]

The following aims toward which to work [illegible]:

1. [illegible] uniformity in demands made by [illegible] of examiners.
2. [illegible] board of examiners
3. [illegible] and complete records in [illegible]
4. [illegible] same standards maintained by [illegible] institutions.

[illegible]

1. [illegible] each accredited school of nursing [illegible] to simplify and make records more [illegible]
2. [illegible] boards of examiners study their [illegible] make them simpler and more [illegible]
3. [illegible] the subject be presented in much [illegible] in the program at the next con[illegible]

[illegible], Vanderbilt University, pre[illegible] Conference on Extra-Curricular [illegible] Wheeler spoke of the [illegible] activities in order to [illegible] [illegible] Hartford Hospital, Hartford, Conn., feels that extra-curricular activities come as the result of need on the part of the students and cannot be forced. In her school a beginning was made in a glee club, some five years ago, and out of this has grown up a dramatic club, a swimming club, and a Girl Scout troup. It is important to have well trained coaches for these activities and a small fee from the students will provide necessary funds. Five dollars a year allows any student to join any club. Through the Y. W. C. A. basket ball and swimming have been developed; the glee club gives a yearly concert; they have theatricals also. Such activities require supervision of which students are not aware. If a club seems to be falling down, Miss McConnell sends out a questionnaire to learn what is wrong. This has been very helpful. Students must work out their own extra-curricular activities. It is better if they manage them themselves. Through their activities so far the Board of Trustees has come to realize the need for a gymnasium which will shortly be forthcoming. The clubs have earned enough money to send two delegates to all conventions, including the International at Montreal.

There was not time for the paper by Miss Zilly of the University of Wisconsin.

At the conference on the "Value of Extra-Hospital Experience in Obstetrical Nursing and Pediatric Nursing" presided over by Helen Wood, Strong Memorial Hospital, Rochester, N. Y., four excellent short papers were presented. Georgia Hukill, Maternity Hospital, Cleveland, described the type of student experience obtainable through an active out-patient department, concluding that it is a satisfactory supplement to hospital experience for both student and post-graduate.

Mabel Selin, Grant Hospital, Columbus, Ohio, described an extra-mural service financed in part by the school desiring the service and in part by the coöperating visiting nurse association. The two extra-hospital affiliations at Yale, one with the Visiting Nurse Association and one with the Nursery School, were briefly described. These students gain knowledge of the normal child as well as of the sick child in his own home. All the papers indicated very thoughtful and coöperative programs, including details of assignment, supervision, costs and records. On the matter of costs, Miss Gardner stated that in the Providence Visiting Nurse Association it was felt that seven students justified the appointment of one supervisor. The consensus of opinion was that extra-hospital affiliations in both branches are a valuable

[illegible]

[illegible]

A[illegible]

[illegible]

H[illegible]

[illegible] Other [illegible] lake [illegible] and [illegible] of [illegible]

[illegible] truly [illegible] of them [illegible] Many [illegible] the [illegible] to [illegible] Such [illegible] of [illegible]

N. O. P. H. N.

D[illegible], discussing the subject "[illegible]" at [illegible] spoke of [illegible] students [illegible] will [illegible] *Nurse.* [illegible]

[illegible] disease [illegible] with [illegible] girls [illegible] profession [illegible] few [illegible] have [illegible] nurses [illegible] recent [illegible] me re[illegible] a class [illegible] were [illegible] by the [illegible] This [illegible] ally [illegible]

[illegible] Chicago [illegible] of [illegible] were [illegible] of [illegible] found [illegible] 2.2 [illegible] in [illegible]

[illegible] that [illegible]

[illegible] between the ages of twenty-[illegible] thirty, three-fourths of their disability [illegible] tuberculosis.

[illegible] to the Disease

[illegible] the greatest of all causes for the [illegible] of tuberculosis among nurses [illegible] to this disease while in training. [illegible] time it was believed that adults [illegible] danger of exposure. It was [illegible] everyone had been infected in [illegible] and further exposure was not [illegible]. We now know that not all young [illegible] been infected. In fact, in certain [illegible] country less than 40 per cent of [illegible] college age have been infected [illegible]. Therefore, exposure is [illegible] to them as to an infant. [illegible] learned that those who react [illegible] tuberculin test are in danger [illegible] when exposed to tubercle bacilli. [illegible] shows that our [illegible] of little or no avail as far as [illegible] spread of tuberculous infection [illegible]. In a study now [illegible] have found less than 30 per [illegible] pupil nurses reacting positively [illegible] to training schools. [illegible] every six months [illegible] and is applied to all who [illegible] negatively. In addition [illegible] have applied tuberculin tests to the [illegible] of nurses in several training [illegible] for [illegible] among the senior pupil nurses [illegible]

[illegible] in this country have very [illegible] that no tuberculous [illegible] admitted either for diagnosis [illegible] [illegible]

[illegible]

"An unusually successful Convention" is the report from those attending the public health nursing meetings. By arranging round tables for those working in communities of a definite population group, by dividing by function, and again by specialty, a new method of covering the innumerable interests of public health nurses was arrived at. The great advantage in this method was a grouping together of those with similar problems from the standpoint of the community, and similar problems from the standpoint of function. Thus the board members met while executives, supervisors and staff nurses were meeting; the rural nurses, nurses in cities of less than 50,000, 50,000–200,000 and over, met simultaneously; and industrial and school nursing, tuberculosis, mental hygiene and social hygiene were discussed at special meetings.

N. O. P. H. N.

In all the N. O. P. H. N. sessions one was increasingly conscious of the influence and active participation of board members. Papers on the use of volunteers, methods of keeping board members interested and active, policies to be considered by the board, publicity, the citizen's responsibility for community health, bore witness to the share of lay people in the general program, while teas, luncheons, and a dinner for lay delegates, of which there were more than 100 present, gave opportunities for informal, and we are told, very live discussions.

The interplay of official and non-official groups in relation to community problems—particularly communicable disease, the correlation of services in small agencies, the place of mental hygiene in public health nursing agencies, the opportunities and promise of the industrial nursing field—might be cited as the outstanding general topics of interest at the Convention. Probably mental hygiene, social hygiene and health education led in interest. There was evidence that both official and non-official agencies were merging their separate programs in joint efforts for the benefit of the community as a whole.

Perhaps it was the ideal convention arrangements, bringing together the meetings of the three organizations under one roof and their offices at one hotel; or perhaps it was the loss, on the eve of the Convention, of a great leader whose spirit pervaded all our activities; or perhaps it was a clearer realization of our mutual problems—whatever the stimulus, there was certainly a feeling of unity of purpose, an integration of effort for common ends and a better understanding of the relationship of the three national nursing organizations which augur well for the future and will mark this convention at Milwaukee as one of the most fruitful ever held.

The new officers of the N. O. P. H. N. are: President, Sophie C. Nelson; vice presidents, Winifred Rand, Ruth Houlton (re-elected); treasurer, Michael Davis; directors, nurse members, [illegible], Katharine Faville, Mrs. Anne L. Hansen, Florence M. Patterson; directors, non-nursing members, Dr. E. L. Bishop, Dr. Haven Emerson, Gertrude Peabody, Dr. Miriam Van Waters.

Registration

PAID registrations at one dollar per person, totalled 3,387. It is known that this is not an accurate picture of the registration, as many neglected, and, we are sorry to say, some unscrupulous nurses failed to register. A complete registration is important, because on the basis of attendance at each convention the next one is planned. It seems incredible that any nurse should have been unwilling to pay a one-dollar registration fee, since these fees are used by the national organizations to defray, in part, the heavy cost of the convention. The loss of income is important, but the failure to gain a really accurate picture of the attendance will be a serious handicap to those planning the next biennial, which is to be at San Antonio, Texas.

Publicity

NEVER has the nursing profession had such a wealth of publicity. Not even the International at Montreal, we believe, was given so much space. Certainly it was not so liberally photographed. The Milwaukee papers and the Associated Press were truly generous but their generosity could not have been so effective without Mrs. O. D. [illegible], Chairman of the Wisconsin Publicity Committee and Virginia [illegible], A. N. A. Publicity Secretary, both of whom prepared in advance for the event. Good publicity does not just happen. It has to be carefully planned. Indeed, if "copy" is to be used widely, it has to be put into the proper hands [illegible] in advance of the event with the "release" date carefully noted. Failure to note the release date caused one paper to announce the award of the Saunders Medal, which was carefully being kept a secret, in advance of the event. Swift apology from the editor was accepted by the officers of the Association, for a wilful violation of that rule constitutes an almost unforgivable sin in newspaper circles. Occasional criticisms of the tone of the publicity were heard. This is a matter of taste. Each paper has its own clientele and caters to particular types of persons. As we check over the material published we note that, even when highly colored by reportorial enthusiasm or [illegible], the essential substance of most of the accounts in which speakers at the Convention were quoted is substantially accurate.

Innovations

AT every convention some steps are taken in advance of earlier years. Among the innovations this year was the use of one hotel as headquarters for the members of the Boards of the three associations. It was a practical device for saving the time of these hard-pushed women. In retrospect it seems but one of many indications of a growing unity of purpose and deepening respect for each other's special contribution to that common purpose.

The daily Bulletin proved a very real improvement over the crowded bulletin boards of past conventions.

The American Nurses' Association's printed copies of such important reports as those of the Treasurer and of some of the major committees, which were presented to delegates when they registered, not only saved time at always crowded business sessions but made for a better informed voting body.

Exhibits

ALMOST one hundred commercial organizations had exhibits at the Convention and a baker's dozen of health and welfare organizations contributed richly to the interest of this lively department. [illegible] Han-[illegible], "convention engineer," who had managed the exhibits at the Health Congress in Atlantic City [illegible] ago, was in charge and again proved [illegible].

[illegible] with [illegible]. Manufacturers of [illegible] charts, models and other [illegible]. [illegible] as [illegible].

[illegible]

[illegible]

[illegible] samples. Nurses constantly could be [illegible] getting in and out of the perfectly [illegible] Ford sedan which occupied the center of the exhibit space. Pharmaceuticals—[illegible] friends and some heretofore less [illegible] were there.

[illegible] Medical Dispensary in Industry, [illegible] by two Wisconsin firms, attracted [illegible] attention and the booths of the welfare organizations were centers of constant activity.

In the A. N. A. booth fresh flowers were kept constantly before the picture of Miss [illegible]. A steady stream of nurses flowed in and out with their questions, their problems, their news of progress, as they did also in the booths of the other nursing organizations and of the Committee on the Grading of Nursing Schools. It would be difficult to evaluate the [illegible] rendered nurses through these centers. The *Journal's* display of simple aids for filing [illegible] material attracted gratifying attention.

A [illegible] map in the booth of the American [illegible] Association had deep significance for all who are working to improve the standards of nursing schools for it showed not only the [illegible] accredited by the state boards of [illegible], but 267 so-called schools [illegible] that they are not so accredited. [illegible] state has 42 non-accredited schools as compared with 34 which are accredited.

[illegible] the booth of the Wisconsin nurses [illegible] epitomized the multitudinous activities [illegible]. Our illustration shows only the [illegible] portion of it. Equally graphic and [illegible] were the map and charts prepared by the Bureau of Nursing Education, [illegible] the location of the schools and the [illegible] a comprehensive picture of [illegible] giving data for each in (1) number of [illegible], (2) daily average of patients, (3) [illegible] of graduates, orderlies and helpers, [illegible] of instruction, (5) number of [illegible] (6) number of general duty graduates, (7) number of students, (8) number of [illegible] students on duty, (9) number of [illegible] students not on floor duty.

On one side of the entrance to the booth was shown an interesting model of a ward of the Milwaukee County Hospital as it was thirty years ago. At the right of the entrance was placed a small exhibit which grew in significance as the Convention progressed. It consisted of a table on which were grouped uniformed dolls—graduates, students, Sisters, Deaconesses, Red Cross nurses and public health nurses. From these dolls ribbons led to the insigne of the state and the legend "We all pull together in Wisconsin." Truly they do, as was demonstrated by the brilliant success of all their planning. Of all the lessons learned at that great Convention perhaps the one shown by the dolls, but lived by the nurses, is most significant. *"We all pull together!"*

Convention Reports

SUBSEQUENT numbers of the *Journal* will contain Convention papers. The July number of the *Public Health Nurse*, purposely somewhat delayed, will be devoted wholly to Convention material and later numbers will also contain important papers.

The N. L. N. E., as usual, will publish a complete report of papers and proceedings in the autumn, and the A. N. A. will get out its "Proceedings" at a fairly early date.

An Invitation from Berlin Nurses

THE German Nurses' Association (Berufsorganisation der Krankenpflegerinnen Deutschlands, 63, Hansemerstrasse, am Heidelbergerplatz, Berlin-Wilmersdorf) wish to make it known that in their Club they have reserved five rooms for the accommodation of foreign nurses passing through Berlin.

The Club is pleasantly and openly situated, most conveniently next to an underground station as well as other means of communication, street cars, etc. The price for a single room, with modern conveniences, including running hot and cold water, is one dollar a night. The price for meals, which can be taken or not as desired, are also very moderate.

Questions

What articles are included in a private duty nurse's bag? What antiseptics is she supposed to carry with her?

R. H.

Preparedness.

So far as we know there is no uniform equipment [illegible]

Two-ounce bottle of green soap
Alcohol [illegible]
Lysol, or some disinfecting solution
[illegible] case containing:
  Surgical scissors
  Forceps
  Probe
  Mouth and rectal thermometers in [illegible] cases
  [illegible]
  [illegible]
  Glass [illegible] tip
  Glass connecting tube
  [illegible]
  Catheter
  Medicine dropper
  Glass piston syringe

The above represents the absolute minimum. It would be well to add the following, at least:

Linen bag containing:
  Fountain syringe
  Rubber rectal tube
  Rubber catheter
  Nail brush (in case)
  Nail file
  Soap (in case)
  [illegible]
  [illegible]
  [illegible]
  Safety pins, rubber bands, vaseline in tube
  Hypodermic outfit
  Flashlight

These items are copied from the *Manual of Public Health Nursing*, published by the N.O.P.H.N. You will note there are no antiseptics listed, which is quite proper. Lysol and alcohol are included for cleansing purposes, and are only for emergencies. Of course, one can usually find these articles in the home.

All letters containing questions, if signed, are given careful consideration and answers are secured from those qualified to give them. Anonymous letters are not answered nor are they given consideration.

* * *

A Warning

A WOMAN [illegible] is using the name of [illegible] Bellevue [illegible] [illegible] and [illegible]

[illegible] sub- [illegible] Ohio. Do [illegible] have signed credentials.

News

News items should be typed, if possible, double space, or written plainly, especially proper names. All items should be sent before the 15th of the month preceding publication.

The American Nurses' Association

Nurses' Relief Fund

REPORT FOR MONTH ENDING MAY 31, 1930

Receipts

Interest on investments	$65.00
Interest on bank balance	18.27

Contributions

[illegible]—No. 5, $20; [illegible]	25.00
[illegible]	251.50
[illegible] $20	20.00
[illegible]	152.00
[illegible]	10.00
[illegible]	10.00
[illegible] No. 4, $75; [illegible]	200.50
[illegible]	$671.27

Disbursements

[illegible]	$2,722.00
[illegible]	1.00
[illegible]	.25
[illegible]	$2,723.25
[illegible]	[illegible]

The Isabel Hampton Robb Memorial Fund

REPORT TO JUNE 12, 1930

Previously acknowledged	$35,049.12

Contributions

Indiana: Huntington County Hospital Alumnae, Huntington	5.00
Iowa: Mercy Hospital Alumnae, Dubuque, $2.50; Park Hospital Alumnae, Mason City, $5	7.50
Minnesota: Northwestern Hospital Alumnae, Minneapolis, $5; St. Barnabas Hospital Alumnae, Minneapolis, $5	10.00
Pennsylvania: Presbyterian Hospital Alumnae, Philadelphia	25.00
Total	$35,096.62

MARY M. RIDDLE, *Treasurer.*

Erna M. Sohmer, Amsterdam, N. Y., has given up the scholarship awarded to her, and it is given, therefore, to the candidate heading the list of alternates,—Beatrice E. Gerrin, Indianapolis, Ind., for study at Teachers College, New York, in the Department of Nursing Education.

The McIsaac Loan Fund

REPORT TO JUNE 12, 1930

May 12, Balance ([illegible] of this amount is held for loans to be paid in September)	$736.32

Contributions

Indiana: Huntington County Hospital Alumnae, Huntington	5.00
Iowa: Mercy Hospital Alumnae, Dubuque, $2.50; Park Hospital Alumnae, Mason City, $5	7.50
Minnesota: Northwestern Hospital Alumnae, Minneapolis, $5; St. Barnabas Hospital Alumnae, Minneapolis, $5	10.00
Pennsylvania: Presbyterian Hospital Alumnae, Philadelphia	25.00
	$783.82
Loan paid	$200.00
Part payment of loan	50.00
Total	$1,033.82

Disbursements

None.	
June 12, Balance	$1,033.82

MARY M. RIDDLE, *Treasurer.*

Scholarships are given once a year, in the spring. Loans are made, if approved, when the state of the treasury warrants. Contributions are desired from associations and individuals interested in promoting nursing education. Checks should be made out separately, in the name of the fund, and sent to the Treasurer, Care *American Journal of Nursing*, 370 Seventh Ave., New York.

* * *

International Catholic Federation of Nurses

A meeting of religious as well as nursing interest held just prior to the Biennial was the ninth annual convention of the International Catholic Federation of Nurses in Milwaukee, June 6–8. Here were seen religious of many orders—Sisters of Charity in their great white cornets, others in the special black bonnets which are associated with their early [illegible], Mother [illegible]; Sisters of the Franciscan order, medical missionaries, and others; together with lay nurses and clergy.

Father Garesché, spiritual adviser of the Federation, in his opening address described the purposes of the organization, which, though primarily for Catholic nurses, is open also to those of other faiths. Its objects are chiefly spiritual, social, and inspirational, furthering the work of, rather than attempting to overlap or encroach upon, the activities of the nursing organizations which have chiefly professional interests. At present there are but two national groups, the United States and the Canadian, although Belgium, Holland, Germany, and France are preparing for affiliation with the International organization. Each national group [illegible] according to its own problems, and hospital administrators and others interested in the care of the sick, as well as nurses, are included in its membership. [illegible], Director of [illegible], St. Francis Hospital, Pittsburgh, Pa., in her address as president of the Federation, dwelt upon the rich heritage which has been handed down to Catholic nurses from the early days of the Church and the fact that [illegible] of this heritage is one of the chief objects. Among the projects for the coming year is the raising of a large sum of money to be used for scholarships and other educational work.

While the purpose of the organization is chiefly religious and social, professional problems were not lost sight of during the meetings. Sister M. Ursula, of St. Vincent's Hospital School of Nursing, New York City, described the case study method as it is carried out in that school, and at a later meeting presented several student case studies. A discussion of timely interest was that of Dr. Robin C. Buerki, Superintendent of the Wisconsin State Hospital, Madison, on striking a balance between the cost of illness and the [illegible]. Dr. Buerki made the important point that while the average length of stay of the patient in the hospital has been reduced nearly 40 per cent, it has been done through improved and expensive methods. Thus while the patient stays in the hospital a fewer number of days than formerly, the per diem cost is greater. This is a fact which the public does not always appreciate.

New opportunities for nurses in specialized fields were made the subject of discussion at the Private Duty Section at which Evelyn Wood, Executive Secretary, Central Council of Nursing Education, Chicago, presided. A paper of particular interest was Dr. Chester O. Guy's which described a field into which few nurses have ventured—that of the laboratory technician. Dr. Guy showed that not only is there a place for nurses in this field, but that salaries are adequate, the work interesting, and the added preparation and experience which the graduate nurse brings to it add much to its interest and to her value as a technician.

Another high point in the Federation meeting was Dr. Francis D. Murphy's description of recent advances in modern medicine and the failure of graduate nurses to keep up with these advances. Dr. Murphy is head of the Department of Medicine at Marquette University and gave from his own experience discouraging illustrations of the fact that many nurses today are little informed as to the nature of the disease from which the patients whom they are called to care for suffer. This lack of interest in medical nursing and the inability of many graduate nurses to deal with metabolic disorders, [illegible] of [illegible] to [illegible]

Other interesting papers read at the Federation meetings were those of Mrs. [illegible], Director of [illegible], Chicago, on "[illegible] in Catholic Charity," and that of Sister M. Madeleva, C.S.C., Ph.D., a poet, head of the Department of English, St. Mary's College, Notre Dame, Indiana, on "Reading for Nurses." [illegible]

[illegible] suggestions and a bibliography [illegible] for patients were presented by a [illegible] the staff of the Milwaukee Public [illegible].

[illegible] of the Federation elected for the [illegible]: President, Mary I. Walsh, [illegible], Gary, Ind.; vice presidents, [illegible], St. Mary's Hospital, [illegible], and Lyda O'Shea, Chicago, Ill.; [illegible] M. Evelyn Donnelly, Brooklyn, [illegible] secretary, Mary Dow-[illegible] York; recording secretary, Emma [illegible] Cleveland, Ohio; directors newly [illegible] Helen Jarrell of Chicago; Sister [illegible] of Chicago; Sister Anne of [illegible]; Sister Victoria of Ashland, Wis., [illegible] of New York. Lay coun-[illegible] Kathryn McGovern, Minneapolis, [illegible], Pittsburgh; Eugenia Ken-[illegible], Lyda O'Shea, Chicago; [illegible] LaRue, Milwaukee. Francis P. [illegible] of the Chemical Founda-[illegible] as Honorary Member. The [illegible] of the Federation meeting [illegible] on Sunday morning to the [illegible] on the summit of Holy Hill, the highest point in eastern Wisconsin.

Army Nurse Corps

During the month of May, 1930, orders [illegible] for the transfer of members of the Army Nurse Corps to the stations indicated: [illegible] General Hospital, El [illegible], 2nd Lieut. Lena M. [illegible]; to [illegible] D. C., 2nd Lieut. Florence C. [illegible] General Hospital, [illegible], 2nd Lieut. Lucille H. [illegible] [illegible] V. Weaver, Bessie Potts, Maude Hansbrough, Glada A. Gage, Elizabeth L. Matyshoke, Hazel E. Warrington, Martha J. Prince, Esther M. Machamer, Cecelia A. Bares, Vera D. Knickerbocker, Winona Swanson, Margaret E. Jenkins, Grace D. McClure, Florence S. Wesonick, Viva B. Brickley, Fern V. Megears, Florence L. Kincaid.

Julia C. Stimson,
Major, Army Nurse Corps,
Superintendent.

Navy Nurse Corps

During the month of May three nurses were appointed and assigned to duty.

Transfers: To Boston, Mass., Edith N. Lindquist, Chief Nurse; to Canacao, P. I., June H. Howard, Florence A. Blanken-Horn; to Chelsea, Mass., Vesta M. Conn, Ella B. Elwell; to Great Lakes, Ill., Margaret W. Barnes; to Guam, Marie Karlen, Olive I. Riley; to League Island, Pa., Elizabeth M. Hewitt, Chief Nurse, Sara E. Taylor, Marian C. Wachtel; to Mare Island, Calif., Edith M. Blair; to Newport, R. I., Carrie Hawkinson; to New York, N. Y., Leah M. Jensen, Carrie S. Albright; to Norfolk, Va., Ada L. Wood; to Pearl Harbor, T. H., Jessie O. Marcoux; to Philadelphia, Pa., Navy Yard Dispensary, Bertha I. Myers, Chief Nurse; to U. S. S. Relief, Agnes C. DeVine, N. Eva Wolfe; to San Diego, Calif., Rose E. Fitzgerald; to Twelfth Naval District, Della I. Killeen; to Washington, D. C., Minnie I. Pipher, Irene Pfisterer.

Separated from the Service: A. Frances Womack.

The Corps reports with regret the death of Agnes J. Gilson, which occurred at the Naval Hospital, Pensacola, Fla., on May 19, 1930.

J. Beatrice Bowman, R.N.,
Supt., Navy Nurse Corps

U. S. Public Health Service

The following transfers, reinstatements and new appointments have been made in the U. S. Public Health Service during the month of May, 1930.

Transfers: To [illegible], N. Y., Katherine G. [illegible]; to Chicago, Ill., Daisy Anderson; to Detroit, Mich., [illegible] Williams, [illegible].

Reinstatements: Mrs. Lucy S. [illegible], Mary Evans Walker, Betty L. Smith.

[illegible]

[illegible] from [illegible] [illegible]tall, [illegible] [illegible] Alice [illegible] [illegible]y, [illegible] [illegible]yne [illegible] [illegible]ew, [illegible] [illegible]dy, [illegible] [illegible]ith, [illegible] [illegible]gh, [illegible]

[illegible] Ga., [illegible]

[illegible]

[illegible], U. S. V. B.

◆

U. S. Indian Service

During the month of May the following [illegible] per[illegible]

[illegible]

[illegible] to Pine Ridge Agency, South Dakota.

[illegible] D. [illegible],
[illegible] of Nurses.

◆

[illegible]

[illegible] these conferences, a week [illegible] probably at Saratoga [illegible] 1931, will be arranged. [illegible] is registered [illegible] with the State [illegible] by July 15 and [illegible] New York University by [illegible] the completion of the course [illegible] given a certificate of two [illegible] by the Extension Division of [illegible] University.

* * *

[illegible] *Boards of Examiners*

[illegible] Martha E. Friend has been [illegible] of the MARYLAND [illegible] OF EXAMINERS, succeeding [illegible].

[illegible] The MASSACHUSETTS STATE BOARD [illegible] will hold its [illegible] meeting at the Edwards Hotel [illegible] July 1 and 2. [illegible]

[illegible] Ida A. Nutter of Portland [illegible] a member of the [illegible], and at a recent [illegible] she was elected [illegible] by the death [illegible] was [illegible] of the Board.

[illegible] The PENNSYLVANIA STATE [illegible] [illegible]

* * *

[illegible]

Aspects of Nursing." The remainder of the morning was given over to a round-table discussion of questions pertaining to training-school administration that had been submitted to the Chairman.

The Public Health Nursing Section had "Mental Hygiene" for its program. Dr. James McCartney, Director, Division Mental Hygiene, State Department of Health, opened the meeting by a discussion of "Mental Hygiene Facilities in Connecticut and How They May Be Used by Public Health Nurses." This was followed by a talk by Dr. E. S. Rademacher, Yale University, Department of Mental Hygiene and Psychiatry, who spoke on "Ways of Developing Mental Hygiene Insight on a Public Health Nursing Staff." In the business session a discussion took place regarding the lack of sufficient number of beds in the state sanatoria for tuberculous patients. This discussion followed a report which showed that the situation is quite acute with fifty-two public health nursing associations which replied to a questionnaire. Following the discussion it was voted that a letter be sent from this Section to the State Commissioner of Finance, giving this information and asking his cooperation for better facilities for tuberculous patients.

Louise Johnson was chosen chairman of the Private Duty Section, on account of the resignation of Ethel Peck. After the business meeting this Section adjourned to hear the program in the Public Health Nursing Section.

At the afternoon meeting, the Mental Hygiene program was continued. The special subject for the afternoon was "Mental Hygiene Clinics," which was introduced by [illegible] Executive Secretary, Connecticut Society for Mental Hygiene. This was followed by a presentation of a Staff Conference by Dr. E. S. Rademacher and [illegible].

The purpose in arranging such a staff conference [illegible] to show the way in which [illegible] in a clinic, [illegible] before a [illegible] in which the [illegible] it was [illegible]

[illegible]

[illegible]

[illegible] reor- [illegible] it [illegible] The [illegible] Mil- [illegible] and

[illegible] National [illegible] nurses [illegible] the [illegible] U. S. [illegible] Cross [illegible] the [illegible] during [illegible] future [illegible] the [illegible]

Indiana: The annual convention of the [illegible] and the [illegible] Hotel, [illegible] 25–27. [illegible] their [illegible] are [illegible] cold [illegible]

[illegible] educational seekers to enjoy [illegible] offered in the combined opportu[illegible] summer resort situated in the [illegible] River Valley of southern [illegible] trips over splendid [illegible] highways to such points of [illegible] Cave, Nancy Hanks [illegible] Rock and Pinnacle on the [illegible] Drive and various others [illegible] of fifty miles.

[illegible] The twenty-seventh an[illegible] of the MASSACHUSETTS STATE [illegible] was held on May 17, [illegible] Women's Christian Association, [illegible] a registration of 265. The [illegible] League of Nursing Education [illegible] annual meeting at the same time. [illegible] were held in the morning. [illegible] Chairman, presided at the [illegible] Section, with the following [illegible] "Community Relationships"— [illegible] and Responsibility of the [illegible] Furthering Public Health," Mrs. [illegible] President, Visiting Nurse [illegible] New Haven, Conn.; "The Rela[illegible] the Nurse to Community Re[illegible] Responsibility for Stimulating [illegible] Lett, Director, Visiting [illegible] Hartford; "The Rela[illegible] the Nurse to the Health-Officer [illegible] Francis P. Denny, Health [illegible] Mass.; Discussion, Dr. [illegible] Commissioner of Public

[illegible] J. W. Rice presided at the Private [illegible] which included a paper on "The [illegible] Nurse as Seen by a Hospital [illegible] Administrator," by [illegible] Assistant Professor of [illegible] University School of Nursing. [illegible] Chairman, Virginia J. W. [illegible] Heights; vice chairmen, [illegible] of Lynn and Alice E. Mc[illegible] secretary, Helen L. [illegible] The next luncheon was [illegible]

[illegible] the Association was for the [illegible] Allen, the President, [illegible] as a prerequisite, membership in the State and the American Nurses' Associations. The chief business of the meeting was to vote on new by-laws presented by the Revision Committee whereby the state would be divided into five districts. With only a few minor changes these by-laws were voted upon favorably. The Massachusetts State Nurses' Association has now voted to reorganize itself into districts which will bring it into complete accord with the American Nurses' Association. The state will be divided into five district associations. It is planned to put machinery into motion immediately to set up these district associations that they may begin to function as soon as possible. The following officers were elected: President, Bertha W. Allen, Newton Lower Falls; vice-presidents, Sally Johnson, Boston, and Blanche A. Blackman, Springfield; corresponding secretary, Elizabeth Ross, West Newton; recording secretary, Mary Alice McMahon, Boston; treasurer, Emma M. Nichols, West Roxbury.

SOUTH DAKOTA: The SOUTH DAKOTA STATE ASSOCIATION OF GRADUATE NURSES will hold its annual convention at Rapid City on July 28, 29 and 30. The headquarters will be at the Alex Johnson Hotel. The following people will appear on the program: Dora M. Cornelisen of the *American Journal of Nursing*, Mary E. Gladwin of Akron, Ohio, and Mildred Smith of the National Commission for the Prevention of Blindness. This meeting should make a desirable vacation trip.

TEXAS: The twenty-third annual meeting of the GRADUATE NURSES' ASSOCIATION OF TEXAS was held in Beaumont, May 7–9. The Board of Directors met at a breakfast given by District No. 12. A meeting was held after the breakfast, followed by a meeting of the Advisory Board. The convention proper was opened at 9 a.m. by Mrs. H. H. [illegible], the President. An address of welcome was given by Mr. Roberts and the responses by Mrs. Little, District 10, Mrs. [illegible], District 14, and Miss Thomas, District 13. Corpus Christi, Fort Worth and Galveston tendered invitations for the 1931 meeting. The secretary's report, the treasurer's report and those of standing committees were given. The assets of the Association were almost [illegible], in spite of the fact that the Association is financing the Summer School at Austin, has subsidized Headquarters, and the Association supports the Grading Committee, Relief Fund, Robb Memorial, and Student Loan Fund, and has over [illegible] out in loans to nurses. The

[illegible]

the Cavalier Hotel, with Ruth Epperson presiding. At this banquet were given reports of the various alumnae associations, and an address by Dr. P. Roland Wagner, Norfolk. Some very clever entertainments were arranged by the nurses of the 4th or Norfolk District. The whole spirit of the occasion was one of festivity and friendliness. All will long remember it.

On Saturday, at 9 a.m., three round-table discussions were held. Private Duty was conducted by Beatrice Bell; Public Health by Rebecca Kneebone, and the Superintendents and Instructors by Marie Baptist. At 11 a.m. the final business session was held, with installation of new officers. They are as follows: President, Emma Harlan, Charlottesville; vice presidents, Blanche Webb, Norfolk, and Ruth Morton, Richmond; treasurer, Mrs. Jessie Faris, Richmond; secretary, Mary Stilwell, Roanoke.

In addition to the president and the secretary, the Directors for the coming year are: Louise Oates, L. L. Odom, S. Virginia Thacker. The fleet being in, the convention was ended by a visit to the warships, which was much enjoyed, especially by the inland nurses. It was the consensus of opinion that the convention was one of the most satisfactory and enjoyable the members have ever had.

Washington: The twenty-fifth annual meeting of the Washington State Graduate Nurses' Association was held May 8, 9 and 10, in Bellingham. About 125 nurses were in attendance and all parts of the state were represented. Splendid reports of the year's work were made by delegates. The speakers included W. D. Kirkpatrick, M.D., of Bellingham; Dr. Charles Fisher, President of Bellingham Normal School; and Dr. H. D. [illegible], State Superintendent of Education. Very interesting round-table discussions were held on "Work of the Grading Committee," "Problems of the Private Duty Nurse," "Case Study as a Method of Teaching," [illegible]

[illegible]

[illegible]

District and Alumnae News

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[illegible]

[illegible]

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[illegible]

[illegible]

[illegible]

[illegible] The senior nurses of the [illegible] were guests. "Cancer" was [illegible] the papers given, one by Dr. [illegible] of the State Department of [illegible] by Dr. Langdon Thaxter. [illegible] will be held in September at [illegible], Portland.

[illegible] Brighton.—At the April [illegible] of St. Elizabeth's [illegible] members were elected [illegible] for the coming year: President, [illegible]; vice president, Lena [illegible], Marie DeLovey; treasurer, [illegible] Devlin; and three councillors. [illegible] Secretary is Mary J. Hanrihan. [illegible] a regular meeting of the [illegible] State Infirmary Nurses' [illegible] was held at the Nurses' Home. [illegible] was observed. Members visited [illegible] in accordance with approach- [illegible] Day. Education of the student [illegible] of an address on "Improve- [illegible] Technic and Equipment." [illegible] of a bedside clinic was given. [illegible] Hospital Nurses' [illegible] held an open meeting [illegible] on May 23. Carrie M. Hall, [illegible] of Nurses at the Peter Bent [illegible], spoke on "The Work of [illegible]."

[illegible] Grand Rapids.—Butterworth [illegible] of Nursing held graduat- [illegible] a class of thirty-nine, on May [illegible] Presbyterial. Dr. Edward [illegible], President of Hope College, [illegible] the graduating address, his [illegible] "People and Persons." Jack- [illegible] May 15, at the banquet of the [illegible] of St. Mary's Hos- [illegible] of Detroit spoke on "The [illegible] of the Future." Kal- [illegible] Day was fittingly ob- [illegible] Hospital on May 12, when [illegible] through the various de- [illegible] hospital. Members of the [illegible] and students assisted the [illegible] the guests. Lansing.— [illegible] Place are under way to start a District there in the fall of this year.

Missouri: St. Louis.—Janet C. Bond, connected for many years with the City Hospital, has resigned as superintendent of nurses and has accepted a position at Mt. Sinai Hospital, Cleveland, Ohio. Miss Bond will be greatly missed from the District Association and the League of which she was an active member. The graduation exercises of the WASHINGTON UNIVERSITY SCHOOL OF NURSING were held as part of the University commencement on June 10, the address being given by Professor John Duncan Ernst Spaeth of Princeton.

New Hampshire: Claremont.—At the annual meeting of the CLAREMONT GENERAL HOSPITAL ALUMNAE ASSOCIATION, held May 20, the following officers were elected: President, Clara E. Hitchings; vice presidents, Mrs. Lillian C. Cole, and Doris M. Wark; secretary, M. Gladys Larrabee; treasurer, Mrs. Clara H. Rice; and three directors. Manchester.—The annual meeting and banquet of the ELLIOT HOSPITAL NURSES' ALUMNAE ASSOCIATION was held at the Rice-Varick Hotel on May 7. There were sixty-five members present, many of whom were from out of town. The graduating class of 1930 were present as guests. Messages of good wishes were read from nurses and friends in distant cities. At the business meeting, Beatrice M. Dugan, President of the Association, presided. The secretary's and treasurer's reports were read and accepted as read. The treasurer reported an increase of approximately $1,000 in the treasury during the past year. It was voted to purchase a utensil sterilizer for the Elliot Hospital, and a committee was appointed to investigate the possibilities of a nurses' rest room at the hospital. Resolutions on the death of Ednah Cameron, class of 1926, were read. The quarterly meeting of the SACRED HEART HOSPITAL TRAINING SCHOOL ALUMNAE ASSOCIATION was held at the Carpenter Memorial Library, May 14. The business meeting was very brief. It was decided to send $25 to the American Nurses' Relief Fund and to hold the next meeting at Concord, and at that time to entertain the undergraduates of the hospital, having the meeting in the form of a picnic. The public meeting opened at 8 p.m., and the speaker was Father John O'Connell, Professor of Philosophy at Boston College. His subject was: "The Christian Woman in Modern Civilization." As guests, the graduate nurses of the city and also the under-

[illegible]

McIntyre, pastor of the First Presbyterian Church, spoke on "The Life of Florence Nightingale." Miss Wiggins, impressive in appropriate dress, appeared as Florence Nightingale herself during the address. "The Lady With the Lamp" was impersonated by Margaret Britt, who made a very beautiful statue, while Elsie Warren read Longfellow's poem. "The Nurse's Prayer" was recited by Kathleen Weldon. After this beautiful and impressive program, Margaret Britt discussed the *American Journal of Nursing* from a student nurse's viewpoint.

Ohio: DISTRICT 1 held a dinner meeting, June 16, at Robinhood Inn, Kent, with the Public Health Section in charge of program. Dr. Roy F. Leslie, Chief Meat and Dairy Inspector, Cleveland, spoke on "The Relation of the Meat and Milk Supply to Human Health." DISTRICT 4 held its regular meeting, May 20. Mr. E. B. Hamlin, Trustee of the National Association of Life Underwriters, spoke on "Insurance." Cleveland.—Commencement exercises for the SCHOOL OF NURSING OF WESTERN RESERVE UNIVERSITY were held in connection with that of other departments of the University, on June 12, in the University Gymnasium, with an address by George Washington Rightmire, LL.D., of Columbus. Cincinnati.—The graduation of the first class from ST. MARY HOSPITAL took place in May and consisted of twelve Sisters. Exercises were held in the hospital chapel. The address was given by Rev. John A. Elbert. DISTRICT 6 held its regular monthly meeting at the University Club, Toledo, May 21, the meeting being in the form of an entertainment in honor of new graduates from all schools of nursing. Mary E. Gladwin was the speaker of the evening.

Oklahoma: Muskogee.—All graduates of the OKLAHOMA BAPTIST HOSPITAL are asked to communicate immediately with Beatrice Thomas, President of the Alumnae Association.

Pennsylvania: Bryn Mawr.—The BRYN MAWR HOSPITAL held graduating exercises for a class of [illegible] on June [illegible], with an address, "The [illegible]," by Dr. [illegible]. [illegible].—The regular meeting of the [illegible] Alumnae Association was held May [illegible]. The [illegible] The class of [illegible] held a reunion dinner to celebrate its [illegible] anniversary, and

[illegible] Hospital, was presented [illegible], on March [illegible] M. Douglas, President of [illegible] Alumnae Association. [illegible] accepted for the [illegible] by Marjorie Anderson. The [illegible], is a fine likeness. [illegible] appreciation of the wonderful [illegible] of Miss McKenzie were given [illegible], who graduated under [illegible] and Dr. Conway, who [illegible] of the staff during those [illegible] by Mrs. Clyde M. Watts, [illegible] the Hospital Aid Society. [illegible] died in Canada, five years [illegible].—The [illegible] held graduating exercises [illegible], in May, with an address by [illegible] Frank O. [illegible].

Deaths

[illegible] M. Crawford (class of 1920, [illegible] Memorial Hospital, Tre-[illegible] May 27, at the hospital, follow-[illegible]. Miss Crawford's death [illegible] year after her graduation. [illegible] private duty nursing. Her [illegible] the funeral in uniform, [illegible] honors. She will be [illegible] classmates and friends.

[illegible] Curtiss (class of 1920, Litchfield [illegible], Winsted, Conn.), on [illegible], after an illness of three [illegible] graduation, Miss Curtiss [illegible] of wards for two years [illegible] supervisor for four years. [illegible] and loved by all who [illegible] was an active member of her [illegible].

[illegible] (Dr. Mary Evelyn [illegible] Paine School [illegible], suddenly, at the [illegible] Va. After [illegible] for a few years, Mrs. [illegible]

Edna Reese (class of 1910, Homeopathic Hospital, now the Millard Fillmore, Buffalo, N. Y.), on March 25, suddenly, after an illness of but a few hours. When the Red Cross called for nurses in August, 1914, Miss Reese volunteered and was assigned to service in England, where she worked at Portsmouth and at Paignton until October, 1915. On her return to this country she signed up for service in the Mexican War and served on the border in 1916 and 1917, when she was recalled to join Base 23 for service in France. Her unexpected death was a great shock to her friends. The funeral services were conducted by the Jane A. Delano Post of the American Legion, and she was buried with military honors.

Anita DeTar Rutter (class of 1926, Kansas City General Hospital, Kansas City, Mo.), on June 5.

Lillian Seatman (class of 1923, St. Louis Baptist Hospital, St. Louis, Mo.), on March 24, from a streptococcic throat infection, after an illness of three days. Miss Seatman was a faithful worker, loved by all who knew her. Burial was at Wright City, her home.

Sister Loretta Mary (Margaret Cook, class of 1915, St. Francis Hospital, Hartford, Conn.) on June 5, at St. Francis Hospital, after an illness of seven months. After her graduation, Miss Cook entered the novitiate of the Sisters of St. Joseph, West Hartford. When her canonical year was terminated she was assigned to St. Francis Hospital where she was in charge of the maternity department and the prepartum and postpartum clinics. She was well qualified for this, her life work, —a brave, courageous spirit, adaptable and progressive, but uncompromising in vigorous loyalty and lofty principles; always helpful, always dependable, she stood a tower of strength and righteousness. She always did all that she should have done, and then much more. She gave of herself without stint, entering lovingly into the lives of her nurses and patients, often giving up her holidays to make days brighter for them. No one knows how wide have been the circles of her influence, but has left a world the richer for her life.

Mrs. [illegible] Adams Richards Van Valkenburg, a Civil War nurse, recently, in the Grand Army Home for Veterans at Waupaca, Wis., at the age of [illegible]. She followed her husband to the front and ministered to any who needed her. The same spirit of helpfulness characterized her later life.

About Books

[illegible] By [illegible] M.D. [illegible] F. A. Davis Company, Philadelphia. [illegible]

WRITTEN especially for the [illegible] at the beginning of her training, [illegible]

[illegible] her [illegible] to [illegible]

The book is based upon the requirements of [illegible] Curriculum. [illegible] the care of the body [illegible] on [illegible] The chapters on [illegible] and on social [illegible] are very [illegible]

[illegible] to be [illegible] it [illegible] for [illegible] the [illegible] been [illegible] be [illegible]

[illegible]

[illegible] AND STAYING WELL. [illegible] tuberculosis patients, [illegible] nurses, and doctors. [illegible] Potts, M.D. 223 pages. [illegible] V. Mosby Company, St. [illegible] Price, $2.

[illegible] publication, as stated in [illegible] introduction by Dr. [illegible], Medical Director of [illegible] Tuberculosis Sana- [illegible] for lay readers" [illegible] technical details of [illegible] are only sug- [illegible]

[illegible] chapter, on suspecting [illegible] should be memorized by [illegible], nurse and interested [illegible]. It is full of such apt [illegible] "People do not die because [illegible], but because of igno- [illegible]." "He (the [illegible] tuberculous usually [illegible] before he looks like [illegible]." Dr. Potts summa- [illegible] of beginning tubercu- [illegible]

> [illegible] weakness or sense of fatigue; [illegible] (3) poor appetite [illegible] leading to loss of weight; [illegible] in the chest.

[illegible] wisely remarks:

> [illegible] the disease were as eager [illegible] as to have an [illegible] they are not tuber- [illegible]

[illegible] on accepting the diag- [illegible] good advice:

> [illegible]

[illegible]

> [illegible] She is an important factor in teaching tuberculosis to the public and is worth far more to the taxpayers and volunteer organizations than she is paid in money.

Two excellent chapters follow on the subject of the sanatorium and the daily routine while there. The author does not hesitate to say that one is no better off in a sanatorium than out of it, if he does not follow the rules commonly accepted and taught by physicians informed on the subject.

The chapter on sanitation reiterates the well known sanitary procedures and precautions necessary to be taken.

There is an excellent chapter on the way to recognize improvement from subjective symptoms and wise counsel is given to the patient who thinks he is well again and able to discontinue the rest cure because he has gained weight, lost his fever, stopped coughing and feels normal, when at rest. A chapter is also devoted to the conflict every tuberculous patient has to face with his or her family, friends and quackery.

The closing chapters consist of those on the outlook of the patient, the poor case and the difference between regret and happiness, the latter depending much on whether or not the excellent advice given in Dr. Potts' book is followed. These chapters contain words of advice on the factors determining the length of time a given individual would probably have to remain under treatment, the all important subject of employment for the ex-patient, as well as an enumeration of the reasons why so many patients break down after returning home from the sanatorium.

Every nurse should be sufficiently interested in tuberculosis to read this important publication, containing information which not only she herself should possess, but which it is hoped she may transmit to her patients and [illegible] book for the [illegible]

[illegible], M.D.

New York

PRACTICAL MASSAGE AND CORRECTIVE EXERCISES WITH APPLIED ANATOMY. By [illegible] [illegible] edition, revised and enlarged by [illegible] [illegible] F. A. Davis Company, Philadelphia. [illegible] Price [illegible]

OUR [illegible]

[illegible] of [illegible] student [illegible] position and [illegible] along [illegible]. [illegible] in [illegible] are [illegible] system, [illegible]. Each [illegible] up in [illegible] re- [illegible] division [illegible] entitled "[illegible]," [illegible] most [illegible] and [illegible] be [illegible] manner [illegible] the [illegible] types [illegible] men- [illegible] in [illegible] should [illegible]

Part III [illegible] the [illegible] various [illegible] have [illegible] Professor [illegible] the [illegible] the [illegible] the [illegible]

[illegible] by week as the patient im[illegible]. The history and progress are [illegible] and specific cases [illegible] benefited by massage. [illegible] has been added entitled [illegible] List of Exercises for [illegible] Conditions."

[illegible] we would suggest [illegible] as a helpful reference, with [illegible] to the instruction given by [illegible] that "it is coöperation [illegible] the medical profession and [illegible] specialist which is de[illegible] necessary to produce the [illegible]."

RUTH DEININGER

[illegible]

[illegible] NURSING AND CHILD CARE. [illegible] E. Turner, Dr.P.H., Nell [illegible] Morgan, R.N., and [illegible] B. Collins. 282 pages. [illegible] D. C. Heath and Co., [illegible] 1930. Price, $1.20.

[illegible] is the outgrowth of the [illegible] which its authors had [illegible] Home Nursing and Child [illegible] in the upper junior [illegible] high schools. There [illegible] on the selection and [illegible] the sickroom, on simple [illegible], on planning the [illegible] there is a sick person to [illegible] at home, on first aid and [illegible] and the control of com[illegible] diseases. There is a very [illegible] on feeding the sick [illegible] both recipes and [illegible]. There are six chap[illegible] child care which dis[illegible] development and [illegible] baby and the [illegible] a [illegible] for [illegible] and Child [illegible] the [illegible]. There are [illegible] illustrations which help to make clear puzzling points in procedure. The book should be very useful both to high school students and to those who are caring for the sick at home.

PEDIATRIC NURSING. By Gladys Sellew, R.N. Second edition, revised. 513 pages. Illustrated. W. B. Saunders Company, Philadelphia. 1930. Price, $2.50.

THIS book has been used by many students in nursing schools and we are glad to receive a new edition. The text remains practically the same except the chapter on Admissions and on Communicable Disease. But value has been added to the former text in the physical arrangement of the book, because the title or opening sentence is not separated from the context. The former first chapter which is not of especial interest to the student nurse as she sees her problem is now at the end of the book. The cross references have been increased and three new cuts added,—the oxygen tent being most useful, as this procedure seems comparatively new.

In the chapter on the Receiving Ward, a carefully detailed outline has been inserted which, although the student might not be able to follow it (on account of hospital routine), would impress her with the principles involved.

The Communicable Disease chapter now presents the problem of the community's protection as well as protection of the student and patient. It takes up routine nursing technic in an isolation room. The subject of diphtheria has been brought up to date and the technic of intubation and tracheotomy added. Meningitis has been transferred to this chapter and only a cross reference made under the Nervous System.

Official Directory

[illegible] Council of Nurses.—Sec., [illegible] 14 Quai des Eaux Vives, [illegible]

[illegible] of Nursing Company. [illegible] Ave., New York.— [illegible]

[illegible]

Association.—Pres., Edith Soule, State Dept. of Health, Augusta, Maine. Sec., Elizabeth Van Patten, 35 Elm St., New Haven, Conn.

Middle Atlantic Division.—Pres., Jane E. Nash, Church Home and Infirmary, Baltimore, Md. Sec., Marion Durell, City Hosp., New York.

Mid-West Division.—Pres., Mabel Dunlap, Moline, Ill. Sec., Grace Ross, 1415 St. Antoine St., Detroit, Mich.

Northwestern Division.—Pres., Mrs. Elizabeth Soule, University of Washington, Seattle, Wash. Sec., Katherine Leahy, University of Washington, Seattle, Wash.

Southern Division.—Pres., Annie M. Beddow, Norwood Hosp., Birmingham, Ala. Sec., Bernadine Bryant, 908 First Ave., Selma, Ala.

Nursing Service, American Red Cross.—Director, Clara D. Noyes, American Red Cross, Washington, D. C.

Army Nurse Corps, U. S. A.—Superintendent, Major Julia C. Stimson, War Department, Washington, D. C.

Navy Nurse Corps, U. S. N.—Superintendent, J. Beatrice Bowman, Bureau of Medicine and Surgery, Department of the Navy, Washington, D. C.

U. S. Public Health Service Nurse Corps.—Superintendent, Lucy Minnigerode, Office of the Surgeon General, U. S. Public Health Service, Washington, D. C.

Nursing Service, U. S. Veterans' Bureau.—Superintendent, Mrs. Mary A. Hickey, Hospital Section, U. S. Veterans' Bureau, Washington, D. C.

Indian Bureau.—Supervisor of Nurses, Elinor D. Gregg, Office of the Medical Director, Bureau of Indian Affairs, Dept. of the Interior, Washington, D. C.

Department of Nursing Education, Teachers College, New York.—Director, Isabel M. Stewart, Teachers College, Columbia University.

State Associations of Nurses

Alabama.—Pres., [illegible] Mobile. Sec., [illegible] N. [illegible] St., [illegible] N. [illegible] St., [illegible]

Arizona.—Pres., [illegible] County [illegible] Sec., Mrs. Martha [illegible] Apt., 3, Douglas. Pres.

[illegible] Sec.-treas., Julia C. Tebo, 1006 [illegible] Bldg., New Orleans.

[illegible]—Pres., Louise P. Hopkins, Room 9, [illegible]. Sec., Mary I. Collins, [illegible]. Pres. examining board, [illegible], Maine General Hospital, Port-[illegible] Mrs. Thomas E. Anderson, [illegible]

[illegible]—Pres., [illegible] E. Nash, Church [illegible] Infirmary, Baltimore. Sec., Sarah [illegible], 1211 Cathedral St., Baltimore. [illegible] Pres., Elsie M. Lawler, Johns [illegible] Hospital, Baltimore. Sec., Frances [illegible], University Hospital, Baltimore. [illegible] board, Helen C. Bartlett, [illegible] St., Baltimore. Sec.-treas., [illegible] C. Friend, 1211 Cathedral St., Balti-[illegible]

[illegible]—Pres., Bertha W. Allen, [illegible] Hospital, Newton Lower Falls. Cor. [illegible], 370 W. Austin St., [illegible]. Ex. Sec., Helena G. Lee, 420 [illegible] St., Boston. Pres. State League, [illegible] Springfield Hosp., Spring-[illegible] [illegible]

[illegible]

Nebraska.—Pres., Blanche Fuller, Methodist Hosp., Omaha. Sec., Gertrude Kranesick, 1023 Sharp Bldg., Lincoln. State League Pres., Mrs. Gladys Smits, Lincoln Genl. Hosp., Lincoln. Sec., Sister Olive Cullenberg, Immanuel Hosp., Omaha. Director nursing education (Temporarily vacant). Bureau of examining board secretary, Ernest M. Pollard, Department of Public Welfare, State House, Lincoln.

Nevada.—Pres., Mrs. Edith Alden, 716 West 6th St., Reno. Sec., Mrs. Lloyd Root, 319 E. Liberty St., Reno. Sec. examining board, Mary E. Evans, 631 West St., Reno.

New Hampshire.—Pres., Louise Thompson, Elliot Hosp., Keene. Sec., Myrtle H. Flanders, City Hall, Concord. Pres. examining board, Marion Garland, Laconia. Sec., Ida A. Nutter, Newington.

New Jersey.—Pres., Kate Madden, Mountainside Hosp., Montclair. Sec., Mrs. Elizabeth Ellis, 215 Johnson Ave., Trenton. Ex. Sec., Arabella R. Creech, 42 Bleecker St., Newark. State League Pres., Eva Caddy, St. Barnabas Hospital, Newark. Sec., Margaret Ashman, Orange Meml. Hosp., Orange. Pres. examining board, Jessie E. West, West Jersey Homeopathic Hospital, Camden. Sec.-treas., Mrs. Agnes Keane Francis, 42 Bleecker St., Newark.

New Mexico.—Pres., Mary P. Wight, 902 E. Silver Ave., Albuquerque. Sec., Alice G. Hollis, 209 N. Edith St., Albuquerque. Pres. examining board, Sister Mary Lawrence, St. Joseph's Hospital, Albuquerque. Sec.-treas., Ella J. Bartlett, 1601 East Silver Ave., Albuquerque.

New York.—Pres., Mrs. Genevieve M. Clifford, City Hospital, Irving Ave., Syracuse. Sec., Lena A. Kranz, State Hospital, Utica. Ex. Sec., Emily J. Hicks, 370 Seventh Ave., New York. State League Pres., Mary E. Robinson, Long Island College Hosp., Brooklyn. Sec., Grace B. Hinckley, Methodist Episcopal Hosp., Brooklyn. Pres. examining board, Sister Immaculate, Convent of Mercy, Rensselaer. Sec., Harriet Bailey, State Education Bldg., Albany.

North Carolina.—Pres., E. A. Kelly, Highsmith Hosp., Fayetteville. Sec., Mrs. Myrtle Hobsen, Health Dept., Greensboro. Ex. Sec., Mary P. Laxton, 305 County Bldg., Asheville. State League Pres., Elizabeth Connelly, Catawba Co. Hosp., Newton. Sec., [illegible] Hill, Statesville. Ed. Dir., [illegible], Mt. Airy. Pres. examining board, [illegible] Mt. Airy. Sec.-treas., Mrs. Dorothy Hayden Conyers, Box 1307, Greensboro.

North Dakota.—Pres., Esther Teichmann, [illegible] St., Bismarck. Cor. Sec., Alice O. [illegible], Grand Forks. Pres. examining board, [illegible], Rugby. Sec., [illegible], General Hospital, Devils Lake.

Ohio.—Pres., Anna C. Gladwin, 208 E. Voris St., Akron. Gen. Sec. and state headquarters, Mrs. E. P. August, 88 E. Gay St., Columbus. Chief Examiner, Caroline V. McKee,

[illegible]

[illegible]